Aveley Medical Centre

Quality Report

22 High Street
Aveley
Brentwood
Essex
RM15 4AD
Tel: 01708 899490
Website: www.aveleymedicalcentre.co.uk

Date of inspection visit: 06 May 2015
Date of publication: 30/07/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Aveley Medical Centre on 06 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all of the population groups we looked at.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Significant events, safety incidents and complaints were recorded, monitored, appropriately reviewed and action taken where required.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice recognised the needs of their practice population and tailored their services to their needs.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients were generally satisfied with the appointments system but it was sometimes difficult to get an appointment with one of the nurses.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice sought feedback from patients through a patient participation group and a patient survey in relation to the services provided.

However there were areas of practice where the provider needs to make improvements

Importantly the provider should;

Summary of findings

- Implement a system to ensure there is an audit trail that reflects that national patient safety and medicine alerts have been actioned.
- Ensure staff meetings are clearly documented to reflect that governance and safety issues are discussed with staff, improvements actioned and that there are clear lines of accountability.
- Keep a record of prescription pads issued to GPs to provide accountability and an audit trail
- Review the use of chaperones to ensure those undertaking the role have received suitable training and carry out a risk assessment as to whether they should be subject to disclosure and barring checks.
- Ensure patients who need to discuss more than one medical issue with a GP or nurse receive an effective consultation.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Significant events and complaints were analysed and learning identified which was cascaded to staff relevant to their role. Records of team meetings did not suggest that learning was cascaded or that staff views were sought and improvement actions implemented. Recording processes for safety incidents were effective. National patient safety and medicines alerts were acted upon but the practice did not routinely record the action taken in response. Staff had received safeguarding and basic life support training. Some staff acting as chaperones had not had formal training or risk assessed to determine if a disclosure and barring check was required. Risks to patients were assessed and well managed. There were enough suitably qualified staff to keep patients safe. Emergency medicines and vaccinations were stored correctly and monitored for expiry dates. Patients had their medicines reviewed on a regular basis. The practice was able to respond to medical emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Data showed patient outcomes were at or above average for the locality. Performance was regularly monitored to achieve targets. Staff were aware of consent guidance including the action to take if a child under 16 years old attended the practice without a parent/guardian. The practice had an effective appraisal system and staff had received training appropriate to their roles and to the needs of patients. Learning and development opportunities were provided for staff. Staff worked with multidisciplinary teams in the coordination and planning of patient care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were satisfied with the way they were treated by the GPs, nurses and other staff. Patients spoken with said they were treated with compassion, dignity and respect and involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand.

Summary of findings

We observed that staff treated patients with kindness and respect and maintained confidentiality. Carers were identified and support offered to them. Carers were offered health checks, advice and winter seasonal flu vaccinations.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG). Patients spoken with commented that they were often unable to contact the practice by phone and that it was difficult to get appointments with the nurses at the practice. Urgent health issues were prioritised and appointments were available the same day. A duty doctor system was in place for immediate health issues, phone consultations and home visits. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had an effective complaints procedure and learning had been identified and shared with staff. The practice had sought feedback from patients through a practice survey and liaison with the Patient Participation Group.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and visible leadership was in place. Staff were aware of the practice vision and their responsibilities in relation to it. Job descriptions and appraisals were meaningful and linked to the practice strategy. There was a clear leadership structure and staff felt supported by management. Staff meetings were used to keep staff informed of learning and practice performance. The records of meetings were brief and did not reflect that improvements had been actioned. The practice had a number of policies and procedures in place to support staff. Clinical leads had been identified in relation to clinical and governance issues. There were systems in place to monitor and improve quality and identify risk. The practice had an active patient participation group (PPG) supported by the lead GP and practice manager. Staff had received inductions, and regular performance reviews. A patient survey was taking place annually. The NHS Friends and Family test results identified that most patients that completed the forms would recommend the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. All patients over 75 had a named GP. Wherever possible patients were able to see their own GP. Carers were identified and offered support and guidance. Home visits and telephone consultations were available to those patients who were house bound. An independent pharmacy was located within the practice for the ease of patients. Home delivery of medicines was available. Staff were trained in safeguarding procedures in relation to the elderly and vulnerable and knew the different signs of abuse. The practice nurses visited elderly people in their homes to provide flu vaccinations. Meetings took place with the community matron who was made aware of the care needs of elderly patients.

People with long term conditions

Good

The practice is rated as good for patients with long-term conditions. Patients had a named GP so they could receive continuity of care. Longer appointments were provided for those patients that needed them. Home visits and telephone consultations were available if they were unable to attend the surgery. Regular reviews took place of their medicines and their general health. Educational talks were arranged to explain about the management of their conditions. Nursing staff had received training to support patients with long-term conditions. Smoking cessation and weight-loss advice was available. Patients identified as at risk of deteriorating health were monitored to reduce the risk of hospital admission. Multidisciplinary team working took place with other healthcare professionals to provide the right care and treatment and a package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Post natal clinics were held to provide advice and guidance to parents. The nurses and GP carried out six week baby checks. Childhood immunisations were available via appointment. Immunisation rates were relatively high for all standard childhood immunisations. Family planning advice was available including the fitting of contraceptive devices. Staff were trained in safeguarding procedures in relation to children and young persons and were pro-active in identifying children at risk. Flexible appointment times

Summary of findings

were available so that children could be seen outside of school hours. Staff understood their responsibilities in relation to Gillick competence with children under 16 requesting appointments without a parent/guardian being present.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Extended opening hours were available on one evening each week and on Saturday mornings. Patients could book appointments up to two weeks in advance and on-line, after registering with the practice for this service. Appointments for emergencies were available daily. Health screening was available for patients to identify any healthcare issues and opportunities for prevention. Lifestyle advice was available for patients to promote healthy living.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Patients with learning disabilities were included on a register and regularly monitored. Annual health checks took place or earlier if required. Longer appointments were available so that issues could be discussed and understood. The practice had made reasonable adjustments to their premises that supported patients with disabilities. Carers were identified and offered appropriate support. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice worked with other healthcare professionals. Longer appointments were available when necessary. Dementia patients were supported by the practice. They were given an annual review of their health and daily needs. Partnership working was taking place to support patients and their carers. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection, comment cards were left with the practice for patients to complete to give their views of the practice and we reviewed 26 cards that patients had completed. Patients made positive comments about the practice and it was evident that they were satisfied with the services provided.

We spoke with three patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. They told us they were given time during consultations and their diagnosis, care and treatment was clearly explained to them. Three patients spoken with expressed that it was difficult to get through on the phone to get an appointment. They said they were treated with dignity and respect and felt involved in the decisions about their care and treatment.

The majority of patients that had completed the NHS Friends and Family test for the first three months of 2015 expressed that they were either extremely likely or likely to recommend the practice.

The patient had an active patient participation group (PPG) that worked with the practice to discuss areas for improvement. We spoke with two of the members on the day of our inspection. They told us that the PPG was well supported by the practice and a GP and the practice manager attended each meeting. They told us that the practice encouraged them to provide ideas and improvements and consulted them about the patient survey and the results received. There were regular newsletters and these and minutes of meetings were displayed on a notice board in reception and available on the practice website. They told us that the practice supported them in identifying areas for improvement.

Areas for improvement

Action the service SHOULD take to improve

- Implement a system to ensure there is an audit trail that reflects that national patient safety and medicine alerts have been actioned.
- Ensure staff meetings are clearly documented to reflect that governance and safety issues are discussed with staff, improvements actioned and that there are clear lines of accountability.
- Keep a record of prescription pads issued to GPs to provide accountability and an audit trail
- Review the use of chaperones to ensure those undertaking the role have received suitable training and carry out a risk assessment as to whether they should be subject to disclosure and barring checks.
- Ensure patients who need to discuss more than one medical issue with a GP or nurse receive an effective consultation.

Aveley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by two CQC inspectors accompanied by a GP specialist advisor.

Background to Aveley Medical Centre

The Aveley Medical Centre is situated in South Ockendon, Essex, on the main high street. The practice is one of 34 GP practices in the Thurrock Clinical Commissioning Group (CCG) area. The practice has a General Medical Services (GMS) contract with the NHS. There are approximately 11,700 patients registered at the practice. There is a branch surgery situated at the nearby South Ockendon Health Centre. Patients registered with the practice have a choice of whether to attend the main or the branch surgery.

The practice has a total of 38 staff, working full and part-time. The practice has five GPs that are partners and there are also three salaried GPs. There is a mixture of male and female GPs. The partners undertake various lead roles and responsibilities are shared between them. The practice undertakes minor surgical procedures.

The GPs are supported by three nurses and one health care assistant. There is a practice manager and an assistant practice manager and a number of support staff who undertake various duties. All support staff at the practice work a range of different hours including full and part-time.

The GPs have surgeries between 9am and 12 noon and 2pm to 6pm on Monday to Friday. There is a late evening session until 8.30pm each Wednesday. The practice is also open for appointments on Saturdays between 8am and 12 noon. The practice has opted out of providing 'out of hours' services which is now provided by South Essex Emergency Doctors Service (SEEDS). Patients can also contact the NHS 111 service to obtain medical advice if necessary.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Detailed findings

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 06 May 2015. During our visit we spoke with a range of staff including three of the partner GPs, a nurse and a healthcare assistant, the practice manager and assistant manager, three reception and one administration member of staff.

We spoke with three patients who used the service and two members of the patient participation group. After the inspection we spoke with a care home manager about their working relationship with the practice.

We observed how people were spoken to at reception and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and reviewed the 26 that had been completed.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. National patient safety and medicines alerts were received by the practice and sent to nominated GPs to review and action. The GPs received a printed copy of the alert and were required to indicate on the printed copy that all appropriate action had been undertaken, and this was then returned to the practice manager. All the GPs spoken with on the day of the inspection displayed knowledge of the alerts and were aware of the system they were supposed to follow.

We found that the system of disseminating the information was effective but there was no formal method in place that provided assurance that all alerts had been acted upon and returned to the practice manager. The practice agreed to review this system to ensure that appropriate action has been taken and there is a completed audit trail.

The practice had effective systems and processes to manage safety incidents. We spoke with several members of staff on the day of our inspection and found that they were aware of their responsibilities to raise concerns, and knew how to report incidents affecting safety. They told us that they would complete a form designed for the purpose and refer the incident to one of the GPs or practice manager. This would then be dealt with immediately if needed or discussed at the next team meeting. We found that the partner GPs and practice manager assumed ownership of safety issues and discussed them at partners meetings and sooner if required.

Staff spoken with were aware of safety incidents that had occurred and told us that these had been discussed at team meetings or through an internal memorandum process if a matter was urgent. They told us of one occasion involving a prescription error. This resulted in a change of procedure and the related form was amended for this purpose.

The practice was aware of the need to display a duty of candour and we found that they had been open, honest and transparent where mistakes had occurred.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The partner GPs assumed responsibility for the analysis and investigation of them in conjunction with the practice manager.

We were told that the learning from significant events and complaints was discussed at meetings or informally. These included a monthly partners' meeting, a weekly clinical meeting and a full staff meeting every four to five months. There was also a system in place if an ad hoc meeting needed to be arranged at short notice to cascade important learning from a significant event that could not wait for a scheduled meeting. In addition the practice used a written memorandum system to notify staff of particular issues or concerns.

We looked at the minutes of the meetings held at the practice and found that they did not contain supporting evidence that significant events had been discussed. Any actions identified had also not been recorded so there was no audit trail that reflected that improvement action had been taken and achieved. However staff spoken with were aware of the learning from safety issues. We were satisfied that appropriate remedial action had been taken but it had not been recorded.

We looked at six significant events that had occurred in the last 12 months. We found that they had been recorded, analysed, investigated and actions for improvement identified. The practice had designed their own form for recording such incidents. Records we viewed reflected that they had been completed effectively.

Reliable safety systems and processes including safeguarding

The practice had a dedicated lead for safeguarding and this was the lead GP. They had been trained to the appropriate level to manage safeguarding matters as had all the other GPs working at the practice. There was a system to highlight vulnerable patients on the practice's electronic record system through the use of coding. The lead GP was aware of those patients at the practice identified as vulnerable and liaised with external agencies as part of a multidisciplinary approach. They attended meetings to discuss safeguarding issues with the local authority whenever they were able. There was a positive relationship with other healthcare professionals such as social workers and school nurses.

Good

Are services safe?

The practice manager was pro-active in monitoring adults and children identified as vulnerable and was involved in discussions with the lead safeguarding GP to ensure that appropriate action had been taken.

The practice monitored when a child did not attend for an appointment and this was then referred to the lead GP as a potential safeguarding issue. They then looked at the patient history to pro-actively look for any safeguarding issue that might be present. Where relevant, enquiries were made with the parent, and if concerns were apparent a safeguarding alert was raised with the local authority.

All staff at the practice had received safeguarding training and those spoken with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of the practice reporting process and who to contact externally if they needed to. A copy of the safeguarding policy was readily available for staff to refer to and they were also aware of the safeguarding lead at the practice.

The practice had a whistle blowing policy and staff we spoke with were aware of it's contents and knew who to contact at the practice or externally if necessary. They told us that they felt confident in raising any issue with the practice manager or one of the GPs and that they would be taken seriously and the matter dealt with in a professional manner.

There was a chaperone policy and staff undertaking these duties were aware of the contents of it. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

We were told that the practice only used clinical staff to undertake chaperone duties and that they had received formal training. However, on speaking with reception staff we found that they had also been occasionally asked to act as a chaperone but they had not received formal training. Staff told us that they were always in view of the patient, never left alone with a patient, could see any examination clearly and that the GP briefed them on the procedure to follow before the consultation. This protected both the GP and the patient. Patient records were updated to reflect that a chaperone had been in attendance at the consultation.

We discussed the training of reception staff on the day of our inspection with the practice manager and they agreed that until they had received training, only clinical staff would carry out chaperone duties. Shortly after the inspection we were contacted by the practice and advised that they had identified a course in the near future so that receptionists could be trained appropriately.

Medicines management

The GPs did not routinely carry medicines when visiting patients away from the practice. If a patient required a prescription on the same day as the consultation, the GP would issue a prescription on the day and deliver it to the pharmacy located within the building. They would then arrange an immediate delivery to the home address of the patient.

All prescriptions were reviewed and signed by a GP before they were given to the patient. This included checking whether a medicine review was due before giving it to the patient. A system was in place on the computerised patient record system to identify patients who were due for a review and this was being actioned.

We looked at the system in place for reviews of repeat prescriptions. We were told that requests were usually received in writing or by email. They were then checked by administration staff against the patients' record then if there were any queries or a patient was due for a review, they were then referred to their allocated GP to authorise the prescription request.

The practice had an independent pharmacy located within the practice during opening hours so that patients could leave and collect their dispensed prescriptions. Information about this was available to patients at reception, in the practice leaflet and on their website.

Prescription pads were stored securely and locked away at the end of the day. The GPs were issued with their own prescription pads but there was no system in place to record the serial numbers of them so that their use could be audited. If a prescription pad was lost or stolen there was no record of the serial numbers available to alert the relevant authorities and prevent misuse of the pads.

The practice monitored their prescribing data and patterns. We found that from the data available to us that the practice was within usual prescribing guidelines. Data was

being shared and there was evidence of learning outcomes. Prescribing rates were monitored through the Clinical Commissioning Group and were discussed at clinical meetings so that all GPs were aware of them.

We looked at how medicines were stored in the medicine fridges and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. Records had been kept and these reflected that the fridges in use were operating within the correct ranges to ensure medicines remained effective. The practice staff followed the cold chain policy when medicines arrived so that they were placed in a fridge as soon as possible.

Processes were in place to check medicines were within their expiry date and suitable for use. We looked at the medicines available in the event of an emergency at the practice, the GPs emergency bag used and stocks of vaccinations used by the nurses at the practice. All the medicines we checked were within their expiry dates.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. They had received the appropriate training to carry out their role and staff files contained certificates to reflect that relevant courses had been attended.

Cleanliness and infection control

Although the lead for infection control was one of the GPs, the day to day management of infection control procedures was shared between the practice manager and the health care assistant. Both had received appropriate training. An infection control policy was available to support staff. This included infection control procedures, the management of needle-stick injuries and clinical waste management.

Staff had received infection control training that included demonstrating to a supervising member of staff that they were aware of hand washing techniques. This was noted in their personal files that a satisfactory standard had been achieved.

We saw that cleaning schedules were in place for the various areas of the premises, cleaning records had been completed and the quality was being monitored. A checklist was available for staff to refer to and complete. An external cleaner was employed to deal with the majority of the cleaning of the practice and appropriate Control of Substances Hazardous to Health (COSHH) guidelines had been followed and recorded. A deep clean took place every six months.

The practice carried out minor surgical procedures and a room was dedicated for that purpose. A more robust cleaning procedure was in place due to the elevated risk of infection from invasive procedures. This included the health care assistant assuming responsibility for this room and the preparation of separate surgical packs for each type of procedure. A checklist was being completed that covered cleaning surfaces between patients and a periodic deep clean. Records had been kept to reflect that cleaning staff had followed the cleaning schedules.

Each nurse working at the practice was responsible for cleaning their own instruments such as spirometers, ear syringes and stethoscopes. Records of this cleaning had been maintained.

We observed the premises to be visibly clean and tidy. This included the consultation and treatment rooms, the reception and waiting area and the toilet facilities. There were adequate supplies of paper towels and liquid soaps for the use of patients and staff. Hand sanitising gel was available in the practice for patients to use. We noted that reception staff used neck-worn sanitising hand gel containers and they told us they used them regularly to reduce the risk of infection.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Clinical staff had received inoculations against the risk of Hepatitis B and it was also offered to non-clinical staff. The effectiveness of this was monitored through regular blood tests. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection. Sharps bins were sited correctly, signed and dated.

An infection control audit had taken place in March 2015. This involved a review of infection control procedures across the whole practice, including a room by room inspection in addition to the cleaning regime and quality. The subsequent analysis and summary reflected that

infection control procedures were robust. An action plan was in place that identified areas for improvement but it was not clear from the documentation whether they had been actioned.

The practice had considered the risks to patients and staff from legionella (Legionella is a term for particular bacteria which can contaminate water systems in buildings). To reduce the risk of legionella the practice ensured that hot and cold water taps were turned on for three minutes each week. Records of this had been maintained.

Equipment

All portable electrical equipment was routinely tested and records we viewed reflected that this had been taking place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and blood/sugar testing equipment for patients with diabetes.

Staff we spoke with told us they had sufficient quantities of equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

We visited several consultation rooms when speaking with the GPs and nursing staff at the practice and found that they were equipped with the expected range of clinical and diagnostic equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the documentation required including proof of identification, references, qualifications and registration with the appropriate professional body. It was practice policy to undertake Disclosure and Barring Service (DBS) checks for all clinical staff but not for support staff, unless their role involved contact with children or vulnerable adults. We found that some reception staff carried out chaperone duties but they had not received DBS checks. At the time of our inspection the practice agreed to review those staff members carrying out this role and undertake DBS checks on them.

The practice manager had received recent training from the Department of Education in relation to recruiting safely. This course covered the procedures to follow when employing new staff. We looked at three staff files and found that the correct documentation was contained within them. We found proof of identity, DBS checks, references and qualifications within the files and for clinical staff, appropriate checks had been made with their professional bodies.

The practice rarely used locum GPs or nurses but when they needed to do so there was a policy in place that outlined the checks that would be made to ensure they were suitable. This included confirming registration with the General Medical Council, evidence of qualifications, experience and satisfactory references.

The practice ensured that staff were appropriately trained to meet the needs of the patient population. Staff training was monitored and reviewed to ensure the right mix of skills and experience supported the patients. We looked at the staffing levels and skills mix and we were satisfied that there were sufficient numbers of skilled staff on duty at all times. Staff said that they often covered for each other at times of annual leave, sickness or when training had been organised.

The GPs had a range of skills mix between them and specialised in different clinical areas. These included skin cancer, early cancer diagnosis, dermatology, safeguarding and paediatric allergies. The nurses specialised in such areas as infection control, asthma, diabetes, smoking cessation and cytology screening.

Staff new to the practice had to undergo an induction process to familiarise themselves with the way the practice was run. We found a record of induction in the staff files that we viewed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A health and safety risk assessment had taken place that identified the risks to both patients and staff. Regular checks of the building and the environment took place and staff were encouraged to report any maintenance issues that presented a risk.

The practice dealt with faulty equipment or fixtures and fittings in a timely manner. Where repairs were required these were actioned or replacement items purchased.

Good

Are services safe?

Other systems were in place to monitor risk including medicine reviews for patients, handling national patient safety and medicines alerts, dealing with emergencies and the servicing, maintenance and calibration of medical equipment.

The practice was pro-active in identifying those patients suffering from conditions that put them at risk of deteriorating rapidly. They were monitored through the use of registers and a multidisciplinary approach with other healthcare professionals. Care plans were put in place to support them and these were regularly reviewed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and the practice had decided this was mandatory. Emergency equipment and appropriate medicines were available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Adult chest pads used with the defibrillator were in date and available but there were no child pads. The practice agreed to purchase some. There was a system in place to monitor expiry dates of emergency medicines and equipment and these were being completed to a satisfactory standard.

We were told of an example where a patient attended the practice suffering from an angina attack. We were told that the staff at the practice responded, administered first aid and made the patient comfortable until the arrival of an ambulance. The patient made a satisfactory recovery.

Staff working at the practice were required to undertake fire emergency training and records reflected that this was being monitored. Individual staff members had been appointed as fire wardens and had received training for the role. The fire alarm had been upgraded and an inspection by the London Fire Brigade reflected that there were robust systems in place in the event of a fire. A fire drill protocol was in place and fire extinguishers were in date and suitably placed allowing easy access for staff. There were signs displayed in reception that explained the evacuation procedure.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This document contained relevant contact details for staff to refer to and the details of external organisations that would be able to provide the necessary support required to maintain some level of service for their patients. These included the action to take in the event of a power failure, the loss of the telephone or computer system, adverse weather and the incapacity of the GPs. Named persons were identified as responsible for key roles if the plan needed to be implemented. The plan had been reviewed in March 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with three GPs on the day of our inspection. We found that consultations were being carried out in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GPs had ready access to the guidelines through their local intranet, could refer to them when necessary and they were keeping up to date with the latest guidelines.

One of the nurses at the practice was trained to undertake consultations with patients for minor coughs and colds. This allowed the GPs at the practice to concentrate on the more complex health needs. Where necessary the nurse would refer a patient to one of the GPs if the consultation revealed a more serious health condition.

On the day of the inspection we found that there were signs on each consultation room to inform patients that they could only discuss one health issue with the GP during their appointment. The wording of this sign was unnecessarily restrictive and may have led to a risk of a relevant health issue remaining undiagnosed or a linked symptom being missed. There was no indication to patients of the availability of double appointments to discuss multiple issues on either the sign on the doors or in reception. We found that the senior partner was clearly supportive of our concerns and we were assured that immediate action was taken to address this issue.

Patients with long term conditions and those approaching the end of their lives through illness had their needs assessed and were provided with effective care and treatment. This involved a multidisciplinary approach with other healthcare professionals being involved in the planning of their care and treatment. Patients and their carers/families were signposted to support from external organisations, such as Macmillan nurses and health visitors. The minutes of meetings reflected that patient's needs were being effectively assessed.

Where any assessment revealed a more complex diagnosis, patients were referred to specialists and other services in a timely manner and where urgent, often on the same day. Staff responsible for the referrals told us that the system was effective and patients were referred in line with national timescales.

Management, monitoring and improving outcomes for people

The practice monitored their performance using the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually.

Staff across the practice had key roles in monitoring and improving outcomes for patients. The accurate coding of patients' conditions, scheduling clinical reviews, and updating patient records when they were discharged from hospital all contributed to the practice performance for QOF. The information staff collected was then collated to support the practice to achieve their QOF targets.

The practice was aware of their patient groups and monitored them through the use of registers. These included patients with long-term conditions such as asthma, atrial fibrillation, cancer, diabetes and hypertension (raised blood pressure). Patients eligible were identified using searches of the patient record system. GPs and nurses at the practice were allocated responsibility for the registers on a shared basis. Patients were then sent letters inviting them to attend for health checks and reviews where they were also provided with advice and guidance as to how to best manage their condition. The system included follow-up calls and text reminders for those patients who did not attend for their appointment.

We looked at the QOF data for the year ending March 2014. The practice monitored their performance throughout the year and it was discussed at clinical meetings. Staff we spoke with confirmed that QOF was being monitored and that they were kept up to date on their current performance either at meetings or informally. This enabled them to make improvements where necessary to provide positive outcomes for patients.

QOF data available to us up to the year end to March 2014 reflected that the practice were similar to other practices nationally as far as their performance was concerned. This included regular health checks for patients with diabetes, reviews of patients suffering with dementia and other mental health conditions and multidisciplinary meetings to ensure patients with palliative care needs received appropriate support and treatment.

Good

Are services effective?

(for example, treatment is effective)

We found that the practice held monthly multidisciplinary meetings with other healthcare professionals to discuss the care and treatment requirements of patients on the palliative care register. These were attended by social workers, community nurses and Macmillan nurses where applicable. Patients were then monitored through the use of care plans that identified their preferred place of care and the most appropriate care and treatment for their needs. These meetings had been recorded and the minutes reflected that patients received individualised care according to their needs.

There was a protocol for repeat prescribing which was in line with national guidance. This ensured that the use of medicines was reviewed to ensure they were effective and safe for continued use. Support staff preparing routine prescriptions regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. A system was in place on the practice electronic record system that highlighted when a review as due.

Appropriate audits had also been carried out in relation to alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). This involved conducting searches on the patient record system, identifying patients on medicines where a risk had been identified, then reviewing the need for the medicine and then changing it if required, after discussing it with the patient. This clinical review was dealt with by the GPs at the practice.

The practice identified and monitored those patients that were at risk of their health deteriorating rapidly. This was an enhanced service they had signed up to with the Clinical Commissioning Group in order to reduce the number of unplanned admissions to hospital. Patients were identified and then their health needs were considered so that the practice could plan their care needs in advance to reduce the risk of a hospital admission.

A number of audits took place at the practice to ensure care and treatment was effective. Three such audits related to the prescribing of different types of medicines. We found that there had been an analysis of the findings from the audit and learning had been identified and actioned. There was evidence of re-audit that reflected that improvements had been maintained. Learning had been discussed at clinical meetings and these had been recorded.

We found that the minor surgical procedures that had been carried out were subject to a review to identify whether there had been any complications such as infections or wound issues as a result of the procedures. There had been no issues identified.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training records and saw that staff training was being monitored to ensure they were up to date with attending relevant courses. The records reflected the date of the last training and when the next one was due. The practice had identified mandatory training for their staff and this included information governance, basic life support, safeguarding and infection control.

All clinical and non-clinical staff received annual appraisals that identified learning needs from which action plans were documented. The GPs were responsible for the appraisals of nursing staff and the practice manager for administration staff. The appraisal included a grading that reflected their performance level throughout the year to demonstrate their competency.

Staff spoken with had all received appraisals and felt they were fair and meaningful. They told us that they were given time to prepare for their appraisals and development opportunities were discussed with them. They said that the practice was proactive in providing training and funding for relevant courses where it met the needs of patients. One member of staff told us that they wished to receive training

Good

Are services effective?

(for example, treatment is effective)

in the management of a particular health condition and this had been organised for them. Another staff member was attending a course on learning disabilities on the day of our inspection.

We looked at three staff files and found that letters of thanks from patients and testimonials from other healthcare professionals were contained within them. This provided supporting evidence of their competence and effectiveness.

Reception staff spoken with told us that on occasions they had to deal with patients who could be argumentative. Whilst they tried to deal with these patients in an effective manner they felt they could benefit from some form of conflict training and this had been considered by the practice manager who was in the process of organising this for them.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. This included the administration of vaccines, cervical cytology and managing and supporting patients with long term conditions such as diabetes. Staff were able to demonstrate that they had appropriate training to fulfil these roles.

Clinical staff were encouraged to undertake their continual professional development to maintain their skill levels. This is a schedule of learning and additional training on a five year cycle where staff are required to complete a specific number of hours training to maintain their registration with their professional body. Staff records contained evidence that this was being undertaken.

The practice closed on one afternoon each month for training known as 'time to learn.' We were told that this time was put to good effect to provide training in areas such as basic life support and information governance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. We spoke with two members of the administration team who told us that patient records were updated the same day on almost all occasions and there was generally no backlog of outstanding information waiting to be included in the patient's records.

Staff told us that one of the GPs reviewed the information sent to them to identify where follow-up appointments or clinical intervention was required. They made it clear on records they had viewed, whether contacting a patient was routine or urgent and these were actioned appropriately.

The practice worked with four local care homes. Regular visits were made by the GPs at the request of care home staff. One nurse at the practice was allocated one day each week to attend the care homes to monitor their patient's health.

After our inspection we spoke with a member of staff at one of the care homes that received support from the practice. We were told that there was a very positive relationship between the practice and the care home and that when a resident of the care home was unwell, the GPs/nurse attended promptly to provide a consultation. They told us that care and treatment was delivered effectively and that prescriptions and repeat prescriptions were issued in a timely manner.

The practice held multidisciplinary team meetings monthly for those patients with long-term conditions or end of life care needs. These meetings were attended by a variety of other healthcare professionals including district nurses, social workers, and palliative care nurses. The needs of patients were discussed individually and decisions about care planning were documented in a shared care record. Minutes of meetings we viewed reflected that patients received individualised care and treatment that met their needs.

Patients with complex health issues requiring specialist input were referred through the 'choose and book' system. Patients were supported in this process if required.

Information sharing

The practice used an electronic patient record system for the patients at the practice. This coordinated, documented and managed patients' care. All staff were trained on the system and able to use it effectively to record and monitor their patients. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Good

Are services effective?

(for example, treatment is effective)

Information was shared with other healthcare providers such as the local GP out-of-hours service. This ensured that patient data was shared in a secure and timely manner. When patients had the need to use the service the results of the consultations were provided to the practice by 8am the following day and patient records updated, after being reviewed by a GP to ensure that a follow-up appointment was not required.

A member of staff had been appointed to summarise patient records onto the computerised patient record system. Staff were aware of the need to maintain confidentiality when sharing information with other healthcare professionals.

Consent to care and treatment

The practice had a consent policy and this was readily available for staff to access. We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We found displayed in one of the consultation rooms a notice outlining the five key principles of the Mental Capacity Act. This helped support staff in dealing with patients and whether they were competent to make decisions about their care and treatment.

Clinical and reception staff were also aware of the consent issue known as Gillick competence. Reception staff told us that if a child under the age of 16 attended for an appointment with a GP or nurse without a parent or guardian and they indicated that they did not want one present, they would be given an appointment. The GPs and nurses we spoke with were aware that they then had to apply the Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

One of the GPs spoken with had recently attended a course in relation to the latest requirements for minor surgical procedures. This course included the types of consent required for such procedures. We found that written consent was being obtained for all surgical procedures and a form was available for that purpose. This included written consent from those patients requiring vaccinations, joint injections and ear syringing.

The practice also had a more detailed consent form when they undertook minor surgical procedures. This included explaining the procedure and outlining any risks present due to the procedure. The form required a signature from the patient.

Nursing staff were aware of the need to consider whether a person attending with a child had the legal right to agree to consent to treatment on their behalf. This included where child immunisations were due and a child attended with a person that might not be legally entitled to consent to treatment on their behalf, such as a step-relative or grandparent.

Health promotion and prevention

The practice was aware of the strategic objectives of the health and social care needs of the local area and directed their services towards them. This information was used to help focus health promotion activity. These included reducing the numbers of smokers and supporting those patients with a weight issue to help them lose weight.

The practice offered smoking cessation advice to their patients. The practice was pro-active in identifying patients who smoked. Patients identified as smokers were written to advising them of the availability of smoking cessation clinics. Patients identified as at risk of their health deteriorating because of their weight, were given advice and guidance about their lifestyle to support them to lose weight.

Patients that smoked or that were over-weight could be referred to a local organisation that provided a six week course to support them to give up smoking and reduce their weight. We were told that the practice had a 40% success rate for smokers that had attended the course and given up smoking. This was above average when compared with other practices that also sent their patients on the same courses.

Similar advice was available in relation to the use of alcohol. Useful information was also available in the practice leaflet.

New patients registering at the practice were offered a health check with one of the GPs at the practice. Patients were required to complete a medical history questionnaire prior to any consultation. Health checks were also offered to patients aged between 35 and 74 and for those over 75.

Good

Are services effective?

(for example, treatment is effective)

Where issues were identified, such as raised blood pressure, this was monitored over a number of weeks after providing lifestyle guidance. If this did not improve the situation they were referred to one of the GPs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

They were aware of the number of children registered at the practice that were eligible to receive immunisations. The most recent performance data up to March 2014 reflected that a high percentage of those children eligible received their immunisation and this was in line and often above the local average in the area.

Flu vaccination data reflected that they were in line with other practices nationally. This included patients over 65 and those in the defined flu clinical risk groups aged between six months and 65 years of age, an example of this being patients suffering with diabetes.

The practice opened Saturday mornings in the winter season so that patients could attend on a weekend to receive their flu vaccination. Posters were displayed on the notice board advertising the availability of flu vaccinations and the practice website also contained relevant information to encourage patients to attend.

Patients eligible for cervical screening were contacted by letter from an NHS central location and advised that they were due for testing. The practice was notified about these patients and monitored their attendance. Those that did not attend were contacted by letter or phone on three more occasions to remind and encourage them to attend for a screening test. Data for the practice performance for the year end March 2014 reflected that the practice was below the national average for cervical screening but improvements had been made in the current year. This included the availability of additional appointments with the nurse on one evening during the week and also on Saturday mornings.

The practice monitored those patients with raised cholesterol levels and contacted them by letter when they were due for a blood test. This helped ensure that their cholesterol levels were regularly monitored to prevent health problems in the future.

The practice had arranged a number of healthcare presentations for their patients at a local library. These were intended to provide education to patients to help them understand and manage their conditions. These included diabetes, weight loss, smoking and asthma. Posters were displayed in the reception area and patients were alerted by text about these presentations. We were told that this was popular with patients and well attended.

The practice leaflet contained useful information for patients in relation to the self-treatment of common illnesses and accidents and advice on maintaining a healthy lifestyle. It also gave advice on the type of general medicines patients could consider purchasing to manage any minor condition or health issue. It also advised patients to consult their local pharmacy about medicines to store in the home.

The practice made positive use of text messages to support the health initiatives they had organised. Reception staff were pro-active in obtaining the latest mobile numbers of their patients and sought permission to contact them about health prevention services. Patients who were eligible for this type of service were contacted by text to inform them that of the services available that were relevant to their individual healthcare needs and when they could attend.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice was aware of the need for patient confidentiality and privacy. The practice leaflet contained information about how the practice handled data held about patients and their information sharing policy. Policies were available for staff in relation to data protection and confidentiality.

The reception area was open plan but the practice had taken steps to protect people's privacy when speaking at the reception desk. A sign requested patients to respect people's privacy by not standing near the reception desk. A touch screen facility was available for patients to check-in for their appointments without the need to discuss health concerns at reception.

Staff we spoke with were aware of the need to treat patients with dignity and respect. They told us that where a confidential matter needed to be discussed patients would be taken to a private room.

Staff acting as chaperones told us that consultations were undertaken with dignity in mind and privacy screens used when the examination was more intimate. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Information from the national patient survey reflected that patients were satisfied with the way they were treated at the practice. The data reflected that 82% found that the GPs treated them with care and concern and 84% for nursing staff. The survey also said that 82% of patients found that reception staff were helpful.

We reviewed other data available for the practice on patient satisfaction by looking at the results of the most recent practice patient survey carried out in February 2014. The practice received 68 completed questionnaires from their patients about the staff and the services provided. The survey included a year by year comparison so that themes and trends could be identified.

The results of that survey reflected that the majority of patients were satisfied with the way they were treated at the practice by clinical and non-clinical staff. We found that where issues had been identified, action was being taken to address and improve them and they were then reviewed at the next survey to establish whether the views of patients had changed. One theme identified was that improvements were required with the appointment system including the availability of appointments and getting through to the practice by phone. In response to this feedback, additional staff were used at peak times to answer telephone calls. The 2015 survey had not yet taken place.

We spoke with three patients on the day of the inspection. They told us that GPs, nurses and reception staff were kind and caring and treated them with respect. Patients did not feel rushed and felt that they received safe care and treatment. One patient was complimentary about the care her baby had received. Patients spoken with would recommend the practice to family and friends. Comment cards we viewed reflected that patients were treated with dignity and respect and that staff were kind and caring.

A system was in place for patients to call the practice to obtain test results. We were told that the identity of the caller would be confirmed before passing on personal information. Patients were able to consent in writing if they wished a relative or carer to receive test results on their behalf.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey from January 2015 reflected that patients felt involved in the planning and the decisions about their care and treatment. We found that 87% of patients said that the GPs were good at listening to them and 87% felt they involved them in decisions about their care and treatment. These were above average for other practices in the area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Some patient feedback on comment cards that we left for them to complete prior to our inspection reflected that sometimes they felt they did not have sufficient time with the GPs and were rushed.

Patients who were elderly and vulnerable, those with long-term conditions, palliative care needs or with complex

Good

Are services caring?

issues were identified and recorded on a disease/condition register. Their on-going care and treatment was discussed with them and they were involved in the care and treatment decisions and plans.

Patient/carer support to cope emotionally with care and treatment

Practice staff were pro-active in identifying those people with caring responsibilities and their details were recorded on the patient record system. The reception area contained information leaflets as to how carers could obtain advice, guidance and support from external organisations. This included advertising the local citizen's advice bureau where support could be accessed in relation to welfare benefits for carers. Carers were offered seasonal flu vaccinations.

Patients suffering bereavement could be referred to an external agency that provided counselling. The practice told us that sympathy cards were sent to relatives of those who had passed away and advice, support and guidance was available from the practice if required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

One of the GPs at the practice was a Clinical Commissioning Group board member and attended regular meetings. This involved engagement with other practices to discuss local needs and service improvements that needed to be prioritised. They were responsible for quality, improvement, prevention and productivity at Clinical Commissioning Group level and had oversight of improvements at the practice.

The patient list was shared amongst the GPs working at the practice but patients could see a GP of their choice when they were available, to maintain continuity of care. Patients over 75 were allocated a named GP and written to personally advising them. The practice was pro-active in identifying patients attaining this age to ensure they were notified about this service.

The practice had an unplanned admissions register where they monitored those patients identified as at risk of their health deteriorating rapidly. Their health condition was regularly reviewed and they were provided with individualised care and treatment to reduce the risk of having to attend the hospital for emergency treatment. This included a care plan and the involvement of community services. Regular multidisciplinary meetings took place where their care and health condition were monitored and discussed.

Once identified as eligible for inclusion on the register, the practice formally wrote to each patient advising them of the service available and informing them of the name of their GP and their care co-ordinator who were responsible for their care.

Patients on this register were provided with a direct telephone number to the practice manager's office for the purpose of booking an appointment. This enabled them to obtain an appointment at short notice or to arrange a telephone consultation or home visit.

Longer appointments were available for patients with multiple or complex needs. When these were allocated to them they were contacted by telephone prior to such appointments to ensure their attendance.

For patients who were house bound, one of the nurses attended their homes to undertake reviews of medicines and to provide services such as ear syringing and flu vaccinations.

The practice had a vulnerable adult's policy and a lead GP had been designated for patients who had learning disabilities. Another GP at the practice assumed this role when the lead GP was away from work. Patients with learning disabilities received annual or more regular health checks from one of the nurses who had undertaken relevant training. They also attended the homes of patients one morning each week for those unable to attend the surgery.

The practice had a GP lead for patients suffering with poor mental health including dementia. A register was used to identify these patients and an annual health review was carried out for them. Data available to us for the year end March 2014 reflected that the practice exceeded the national average for carrying out these reviews. This included providing support and guidance for their social needs in addition to their health care needs.

A system was in place to identify and provide services to mothers and babies. Post natal clinics were held at the practice and one of the nurses undertook this role. New parents were written to and supplied with dates to attend and a child immunisation book. Childhood immunisations were available via appointment and the nurses and GP carried out six/eight week baby checks. Family planning advice was available including the fitting of contraceptive devices.

The practice ran a number of clinics to monitor the health of patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes. Appointments could be booked with the nurses at the practice who monitored their condition and provided lifestyle advice and guidance to support them.

The repeat prescription system was monitored by a dedicated member of staff who was responsible for forwarding the request to one of the GPs for signature after

Good

Are services responsive to people's needs?

(for example, to feedback?)

checking the patient's record to ensure that there were no queries or that a review was due. The GP was then notified if there were any concerns affecting the issuing of a repeat prescription.

Patients who were house bound were able to order repeat prescriptions by phone without the need to attend the surgery. They could also nominate a pharmacy of their choice in the local area who delivered their prescriptions free of charge. Other patients completed request forms and left them in a box in reception, provided for that purpose or could order them online. Prescriptions were dealt with within 48 hours. The practice leaflet contained detailed information about the prescription process.

The practice had sought suggestions for improvements in the way it delivered services in response to feedback from the Patient Participation Group (PPG). This group was active and well supported by the practice. They had provided suggestions for the format of the patient survey questionnaire, text message reminders and the appointment system.

The practice was pro-active in obtaining the most up to date mobile telephone numbers of their patients. They then used these, with consent, to notify patients of some of the services they had in place. These included the days and times of their smoking cessation clinics, diabetes management sessions, flu vaccination clinics and other areas of clinical need. They also contacted patients by phone and by letter.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to their premises so that disabled patients and those with limited mobility could access the service easily. The premises were also suitable for parents with young children. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. A ramp and supporting rails were available at the entrance to the practice. Accessible toilet facilities for the disabled were available for patients. Baby changing facilities were also available.

The practice had a number of vulnerable patients at the practice including those with learning disabilities and dementia. Their services were planned accordingly to meet their needs. The practice did not have patients from the travelling community but they were welcome at the practice if they wished to register.

Access to the service

The practice held surgeries on mornings and afternoons on weekdays at a variety of times. Extended surgery hours were available at the practice on a Saturday between 8am and noon and on Wednesday evenings between 6.30pm and 8.20pm. This was primarily for working or other patients who were unable to attend during normal opening hours and were bookable appointments only. The nurse also provided cytology screening on a Saturday morning for patients with work commitments.

Routine appointments were able to be booked up to two weeks in advance for non-urgent matters. There were a number of emergency appointments available on each day.

The practice recognised those patients that could not attend the practice through illness or mobility issues and there was a system in place for them to receive telephone consultations or home visits. Patients identified as vulnerable to deteriorating health were given a dedicated telephone number so that they could book an appointment at short notice or receive a telephone consultation of home visit.

The practice operated a system where one of the GPs was the 'on call' GP for the day. They were responsible for emergencies, home visits and telephone consultations. When patients rang the practice their needs were discussed and they would receive a call back at the end of the morning surgery or sooner if urgent.

The practice was aware that patients had difficulties in obtaining appointments with the nurses at the practice. They could only be booked in advance and there was a four week wait for appointments. The practice was looking at ways to improve this situation.

On-line booking was also available for patients. They were required to register for this service at the practice before using it. A text message appointment reminder system was also in place.

The practice gave priority to children requiring appointments. Wherever possible they would allocate them an appointment but if this was not possible they

Good

Are services responsive to people's needs?

(for example, to feedback?)

would see them at the end of one of the surgeries. If a child was too ill to attend the practice one of the GPs would call the parent and discuss the health concern over the telephone.

We spoke with three patients on the day of our inspection. They told us that there was sometimes difficulty getting through to the practice on the phone but they could generally get an appointment of their choice. Some found that there was insufficient time allowed with the GPs when discussing more than one issue. This was corroborated on comment cards we viewed, completed by patients prior to the inspection. There was no information available in reception or on the practice website that explained to patients that they could book a longer appointment.

The practice kept patients informed if GP appointments were running late. A sign was displayed in the reception area that advised patients of the length of those delays.

The practice monitored the frequency that patients did not attend for their appointments. This affected both the waiting time and the availability of appointments for other patients. They had conducted an audit of these occurrences and had then implemented an action plan to encourage patients to attend when required. This included notices in the waiting room and reception area, information on the practice website and improvements to the system for booking appointments. It also identified the need for additional staff to answer the telephone at peak periods of demand and to provide reminders for patients by phoning them or sending them a text message.

The practice had a touch screen facility for patients to register that they had arrived for their appointment. This helped reduce queues at reception and reduce delays. The practice leaflet gave guidance to patients as to how to make best use of the appointment system.

Data from the national patient survey from January 2015 reflected that 43% of patients found it easy to get through on the phone, 40% usually waited 15 minutes or less after their appointment time to be seen and 53% described their experience as good when making appointments. These were all below the local Clinical Commissioning Group average for practices in the area.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information about the complaints procedure was available in the reception area, in the practice leaflet and on the practice website. There was also a complaints/comments box that patients could use.

Staff we spoke with were aware of the procedures to follow and forms for recording complaints were readily available. The practice preferred complaints to be put into writing but a system was in place to note the more minor issues and bring them to the attention of the practice manager so that issues could be addressed and improvements made. They told us that they were informed about the complaints at team meetings

Complaints were co-ordinated through the practice manager in the first instance and then discussed at practice meetings. Complaints about clinical matters were dealt with by the GPs and non-clinical by the practice manager. A log of complaints was maintained and any learning identified was cascaded to staff at team meetings.

We viewed the record of complaints that the practice had received over the last 12 months. We found that they had been recorded in detail, analysed and areas for improvement identified. Where a mistake had been made the practice had provided a duty of candour to the complainant by apologising where relevant and offering them an explanation. This included the offer to discuss the complaint in person with the practice manager.

We also found that some of the complaints had led to procedural improvements. One example related to improving their telephone system by providing a facility that explained to callers their position in the queue waiting to be answered.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a statement of purpose that described their vision, aims and objectives. These included providing a quality service for their patients, treating them with dignity and respect, involving them in decisions about their care and treatment and ensuring that staff had the right skills and training to meet the needs of patients.

All staff members had a job description that described their role and responsibilities. We found that these were linked to the aims and objectives of the practice. Staff spoken with understood their role and how it fitted in with the practice vision and values.

The practice was planning to re-design parts of the building to accommodate another consulting room where additional consultations could take place. Staff at the practice were aware and involved with this future planning.

Governance arrangements

The GP partners at the practice had leadership roles for specific clinical areas. These included information governance, mental health, palliative care and safeguarding. The practice manager also had a number of lead roles including a shared infection control role with the health care assistant.

One of the staff members at the practice was the lead for information governance and had received training to carry out this role. The practice used the information governance toolkit. This is an online NHS governance system that enables the practice to assess themselves against Department of Health Information Governance policies and standards. The practice had achieved a grading of level two in relation to information governance for the year 2014 to 2015 and this meant that governance at the practice was at a satisfactory standard.

The practice had a range of policies and procedures in place to govern activity and these were available to staff within the practice. We looked at several of these policies and procedures and found they were fit for purpose and were being reviewed annually. Staff members were required to sign each policy to reflect that they had read and understood each policy.

The partners held monthly management meetings with the practice manager. Weekly clinical meetings also took place with the GPs and nursing staff and a full staff meeting every four to five months. All meetings were minuted and made available to staff that were unable to attend. We looked at the minutes of a selection of these meetings and found that they lacked in detail and did not contain evidence that issues had been discussed, actions identified and then an audit trail for completion. We were satisfied that staff had been made aware of relevant issues as they were able to tell us about them. The practice have agreed to record their meetings in a way that demonstrates that learning has been identified, areas for improvement identified and then action taken to improve services.

The practice did not have a formal clinical audit system in place but the GPs did carry out reviews and audits on an individual basis. We saw evidence of a number of prescribing audits/reviews that had taken place including non-steroid medicines, diabetic blood test strips and antibiotics. We also saw a completed audit cycle relating to special medicines that had been prescribed. The audits we viewed contained an aim, the criteria for the audit, the findings and recommendations.

We also saw that a non-clinical audit had taken place which looked at the number of patients failing to attend for an appointment they had booked. The practice had identified where they could make improvements to reduce the number of patients failing to attend, including placing signs in the waiting room, writing to patients who did not attend and text message reminders prior to the day of appointment.

We spoke with the clinical and non-clinical staff and all were aware of the staff members in leadership roles. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

The partners at the practice held regular meetings to discuss the management and performance at the practice. They also discussed learning from significant events, safety issues and complaints.

Staff meetings also took place and there was a system in place to ensure staff were up to date on any relevant information or improvements that affected the practice. We

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

did find however those minutes of meetings were not recorded in sufficient detail to evidence that governance issues had been discussed and that any actions identified had been completed.

Staff spoken with told us they felt supported by the GPs and the practice manager and said they were readily available for advice and guidance on clinical and non-clinical matters. Staff spoken with told us that there was an open culture at the practice and that they were encouraged to raise any concerns or offer ideas for improvement. They told us that the GP partners and practice manager were approachable, supportive and readily available for advice and guidance.

Seeking and acting on feedback from patients, public and staff

The practice had undertaken a patient survey in February 2014 to seek the views of their patients about the services provided. There were 68 replies to the questionnaires sent to patients. Patients were asked about their views of the services provided including the appointment system, friendliness of staff, the prescription system and whether patients would recommend the practice to family or friends.

An analysis of the findings had been undertaken which had identified areas for improvement. One such improvement was in relation to the availability of appointments. They had taken action by appointing an additional member of staff in the mornings to deal with the telephone demand and by educating patients about the impact on others if they did not attend for their appointment. They also had a long term plan to re-structure the building to accommodate an additional consulting room.

The practice had an active Patient Participation Group (PPG). This is a group of patients registered with a practice who work with them to improve services and the quality of care. The membership of the PPG was small but productive and we were told that it had been difficult to recruit patients to give their time, despite notices in reception and on their website, encouraging patients to join. There were four patients who met face to face on a regular basis and approximately 20 other members who submitted ideas for improvement by email.

On the day of the inspection we met with two members of the PPG. They told us that there was a positive relationship between the practice and the PPG and that the practice manager and lead GP attended meetings with them. They told us that their ideas for improving the services were sought and they were consulted about the questions that patients would be asked for the patient survey. Newsletters were published in the reception area and on the practice website and minutes of meetings were also made available for patients to read.

Ideas and suggestions they were involved with included improving the telephone and on-line appointment system, notes added to prescriptions to remind patients of the availability of healthcare clinics and the marketing of educational talks about healthcare issues such as diabetes management, weight loss and smoking cessation.

The practice had recently started the Friends and Family test and this was reviewed monthly. This is a test where patients are requested to complete a short questionnaire about their experience at the practice. Forms were available for patients to complete in the reception area and also on the practice website. The results of the family and friends test indicated that a high percentage of patients would be extremely likely or likely to recommend the practice. This was a positive trend for the first three months of 2015.

Staff we spoke with told us that they were encouraged to provide feedback about the services provided to identify improvements. They said that this was on an informal basis with the practice manager, at staff meetings and when they received their annual appraisals.

Management lead through learning and improvement

GPs and other staff at the practice attended various learning events so that they could be up to date with current issues and good practice. These included monthly protected 'time to learn' meetings organised by the CCG. This provided an education programme for clinical and non-clinical staff

Staff were supported to maintain their clinical professional development through training and mentoring. Staff we spoke with told us that appraisals were used to identify learning needs and staff sent on different training courses if they met the needs of patients and benefited the practice.

The practice had completed reviews of significant events, complaints and other incidents and shared the learning

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

from them with staff at team meetings. Staff spoken with had an awareness of the incidents that had occurred in the past and were included in discussing incidents to identify ways of improving services.