Nene Valley Medical Practice

Quality Report

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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 Nene Valley Medical Practice on 19 May 2015. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people was good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also received good quality care.

Our key findings were as follows:

- The practice had a good understanding of the needs of the practice population and services were offered to meet these.
- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in their care.
- There were systems in place to provide a safe, effective, caring and well run service. Practice staff were kind and caring and treated patients with dignity and respect.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made.
- The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- Services provided met the needs of all population groups.
- The practice had strong visible leadership and staff were involved in the vision of providing high quality care and treatment.

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

The provider should:

- Ensure staff have a clear understanding of the Mental Capacity Act and their role in implementing it.

Summary of findings

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Staff help patients and those close to them to cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of different patients were taken into account when planning and delivering services. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. Patients could access the right care at the right time. Access to appointments and services were managed to take account of patients' needs, including those with urgent needs. Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. It was responsive to their needs. Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. The practice held 2.4% of its most vulnerable of admission, older patients on an 'unplanned admissions' register'. Home visits and priority appointments (including for patients who were receiving palliative care) were available and the practice aimed to call these patients back within 30 minutes of a home visit request or for any urgent medical problems. Practice audits showed the practice had achieved a 92% call back rate within 30 minutes for these patients with 94% of requests for home visits to older and vulnerable patients visited by a GP on the same day. The practice was actively promoting electronic prescribing (ETP2) and at the last practice audit had achieved 50% of its repeat prescriptions via ETP2. The practice provided cover for a 106 bed nursing home and provided two ward rounds twice a week and visited patients at the home when required. Multi-disciplinary team meetings took place for elderly patients with complex needs. External support was signposted and made available for them to access. Elderly patients had a named GP to receive continuity of care. Telephone consultations were available. The practice was pro-active and encouraged patients to receive flu and pneumococcal vaccinations.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with

Summary of findings

GPs and nurses were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Parents we spoke with were positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice had introduced early morning and late evening extended hours appointments during the week and also Saturday morning appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable those with learning disabilities. Annual health checks for people with learning disabilities were undertaken and patients received annual follow-ups. Double appointment times were offered to patients who were vulnerable or with learning disabilities. All patients were able to register at the practice as temporary residents, regardless of their personal circumstances, including the homeless and members of the travelling community.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice worked closely with The Carers Trust and in September 2014 was awarded 'Practice of the Month' for their work with carers. In particular the practice had worked closely with the trust to run drop in sessions for carers where they could come to the practice, have a cup of coffee or tea and speak to someone for support and advice. (The Carers Trust provide cover for carers to facilitate a short break or evening off and provide signposting for additional help and support). The practice manager told us there were no other services of this type in the area and the Carers Trust had recognised the practices innovation in working with them on this.

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were aware of the different types of abuse that could occur.

People experiencing poor mental health (including people with dementia)

Good

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered with dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as the mental health charity MIND, Improving Access to Psychological Therapies (IAPT) and the community psychiatric nurse for provision of counselling and support. However not all staff had a clear understanding of the Mental Capacity Act and their role in implementing the Act.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards. Eight were very positive about the service experienced. However we received some less positive feedback on 17 comment cards which we raised with the practice at the time of the inspection, they were aware of the issues of concern raised on the cards and were monitoring the situation. Patients said they felt the practice offered a good service and staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection, they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by all the staff at the practice and that they were provided with plenty of information about their care and treatment. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. They also reported that they could get an appointment and that the practice was responsive to their needs. One patient told us that they were unhappy that urgent appointments were not available for children. However we discussed this with staff who told us urgent appointment requests for children were always prioritised.

We reviewed data from the most recent national GP patient survey. We noted that 96% of patients responding to the survey stated the last appointment with the practice was convenient with 89% stating that they felt the practice was good or very good; these were among the higher range of ratings locally. The survey also showed that patients felt the GP and the nurses were very good at giving them enough time, good at listening to them and good at explaining test results to them and good at involving them in decisions about their care. These satisfaction rates were above the average for both the local Clinical Commissioning Group (CCG) area and for England in general as were the satisfaction rates about patients experience of making an appointment. Generally the survey indicated a positive experience of patients with satisfaction rates in-line with the national average for opening hours and appointment availability.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff have a clear understanding of the Mental Capacity Act and their role in implementing it.

Nene Valley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Nene Valley Medical Practice

Nene Valley Medical Practice provides general medical services Monday to Friday from 8am to 6.00pm with a duty doctor available Monday to Friday until 6.30pm. The practice offered extended hours appointments to to enable better access for patients at variable times and days during the week. Weekday mornings from 7am to 8am or evenings 6.30pm to 8pm, and Saturday mornings from 8am to 11am. These were only available as pre-booked appointments and not on the day. The practice provides general medical services to approximately 12,493 patients and is situated in Clayton, Orton Goldhay, near Peterborough. The purpose built premises provide good access with accessible toilets and car parking facilities, including spaces for those who are disabled.

The practice has a team of seven GPs meeting patients' needs. Five GPs are partners meaning they hold managerial and financial responsibility for the practice. The practice employs one Nurse Practitioner, one Nurse Prescriber, two practice nurses and two healthcare assistants/ phlebotomists. In addition there is a practice manager/ partner, assistant practice manager, a team of medical administrators, secretaries, summarisers, prescribing clerks and receptionists.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, counsellors, support workers, on site ultra-sound scanning facility, health visitors and midwives.

The practice provides services to a diverse population age group, in a residential location. The practice provides GP cover for a 106 bed nursing home and provides two ward rounds twice a week.

The practice is a training practice, training medical students from Cambridge University.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place. From 1 June 2015 the practice was moving its appointment system to a GP telephone triage service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

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)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. During our inspection we spoke with a range of staff including GP partners, practice nurses, a health care assistant, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff described how they had liaised with other health care professionals when they had concerns regarding a patient's safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. There was evidence of systems in place to review and monitor incidents. Staff told us they felt these were working well. This showed the practice had put plans in place to manage incidents consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and analysing significant events, incidents and accidents. All staff were empowered to report incidents and events. Safety issues and significant events were discussed as a standing agenda item on each monthly practice management meeting where key decisions were made about the practice. Significant events that affected the wider clinical team, including the practice nurses, attached community nurses and health visitors, were discussed at monthly multidisciplinary meetings at which those staff members were present. This ensured that key lessons were shared among all relevant staff.

We looked at a number of records of significant event analyses (SEA) which demonstrated that the practice reviewed the circumstances of such events and learned lessons from them. For example, following a number of missed actions required from hospital letters, the practice had put monitoring systems in place to ensure clinicians reviewed scanned documents with increased diligence for all referral actions required by the practice.

We saw that national safety alerts, for example, about medicines or medical devices, were sent directly to all of the clinical staff and where relevant were discussed at clinical meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing, administrative and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient, including scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example patients diagnosed with dementia, children subject to child protection plans, or those requiring additional support from a carer. There were systems in place to follow up children who persistently failed to attend appointments and for identifying childhood immunisations. For example, one GP described how the practice encouraged attendance and education for childhood immunisation in particular for those patients and families from the local travelling and migrant worker communities. The practice worked closely with local health visitors and due to the number of very complicated immunisation schedules from abroad often needed Public Health involvement.

Good

Are services safe?

There was a chaperone policy. This was visible on the waiting room noticeboard, but not in consulting rooms. We discussed this with the practice manager who agreed to ensure the policy was available in all treatment and consulting rooms. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. There were designated reception staff who would act as a chaperone if nursing staff were not available. Staff who undertook chaperoning had received training and spoke knowledgeably about the correct way this should be undertaken. This included where to stand to be able to observe the examination. Disclosure and Baring Service checks had been undertaken for all staff.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors, the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and 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 and staff were able to clearly describe the actions they would take in the event of a power failure to a vaccine fridge. 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. All the medicines we checked were within their expiry dates. This included the medicines available in the event of an emergency at the practice, the GPs emergency bag used when conducting home visits with patients and stocks of vaccinations used by the nurses at the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. This included checking whether a medicines 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. There were systems in place for reviewing repeat medications for patients with co-morbidities/multiple medications. The practice had made arrangements with local pharmacies so that patients could collect their dispensed prescriptions at local pharmacies.

The practice had recently introduced electronic prescribing (ETP2); this enabled the practice to send patients repeat prescription directly to a pharmacy or dispensary of the patients' choice. Making the prescribing and dispensing of medicines more efficient and convenient for patients and staff. The practice manager told us that the practice had achieved 50% of repeat prescriptions via ETP2, this being the highest in the local Clinical Commissioning Group (CCG) area.

Cleanliness and infection control

The practice had an infection control policy and a lead for infection control who had received appropriate training.

We saw that all staff had undertaken infection control training including hand washing guidance so they understood the appropriate technique to reduce the risk of infection. An infection control audit had taken place every three months and this had been completed to a satisfactory standard. This was planned to continue. Where areas for improvement had been identified these had been actioned in a timely manner. 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.

We observed the premises to be 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. Notices about hand hygiene techniques were displayed in staff and patient toilets. Curtains in consultation rooms were of the disposable variety, and were changed when required or at

regular intervals. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

A cleaning contractor had been appointed to undertake the cleaning of the practice. A schedule was in place that identified the type of cleaning to be undertaken, the frequency and the materials and equipment to be used. This included colour coded mops to reduce the risk of cross contamination. We saw that the quality of the cleaning was monitored by the practice manager and infection control lead.

Clinical staff had received inoculations against the risk of Hepatitis B. The effectiveness of this was monitored through regular blood tests and records had been kept. 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.

The practice had a policy for the management, testing and investigation of legionella. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. However the practice manager advised us they had not received the hardcopy results of these tests from the contractor appointed to undertake them.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers, blood pressure monitors and weight measuring scales including those for patients who used a wheelchair.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we saw that risks around access to the surgery through double entrance doors had been addressed and mitigating actions had been put in place.

Other systems were in place to monitor risk including handling national patient safety alerts, dealing with emergencies and the servicing, maintenance and calibration of medical equipment and medicine reviews for patients,. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff were very aware of the GP leads for safeguarding children and adults. They told us they felt comfortable approaching the safeguarding leads

and as well as any of the clinicians should they have any concerns. Staff described how health visitors or anyone with a safeguarding child or adult concern were able to contact and speak with the duty GP on the day and where necessary an appointment was made available the same day with the duty GP. Staff also described the process they put in place should the health of a patient in the waiting area deteriorate.

Patients with conditions which made them more vulnerable were identified and monitored through the use of registers and a multidisciplinary approach with other healthcare professionals. This provided a systematic, organised approach to identify patients at risk of deteriorating rapidly so that care plans could be put in place to support them.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The document was kept under review and hard copies were located both on and off-site. The document also contained relevant contact details for staff to refer to and external organisations that would be able to provide the necessary support required to maintain some level of service for their patients.

Identified risks were included on a risk log. Each risk was assessed, rated and control actions recorded to manage the risk. These were discussed at GP partners' meetings to ensure any changes in risks were identified and properly managed.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Staff told us they had received training in fire safety. Fire extinguishers we viewed had all been serviced within the last year to ensure their effective operation if needed. All areas of the practice including treatment rooms had a panic button so that clinicians could summon assistance in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We saw that practice management meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were assimilated during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw the practice completed reviews of case notes for patients for example at risk of falls, with diabetes, asthma and hypertension to show they were on appropriate treatment and had received regular reviews of their health and medicine.

We found that GPs led on specialist clinical areas such as mental health, muscoskeletal, sexual health, the management of chronic lung conditions such asthma and chronic obstructive pulmonary disease (COPD) and diabetes. We saw that clinical staff were very open about asking for and providing colleagues with advice and support. Our review of the multidisciplinary team meetings and clinical meeting minutes confirmed that this happened.

The practice had a clear system in place to manage referrals in a timely and effective manner. The practice addressed prescribing practices by individual GPs and actively monitored their performance through continued audit cycles. In addition the practice benefited from the services of an attached pharmacist who offered in-house reviews of patients on multiple and complex medicines. One GP partner showed us data from the local CCG of the practice's performance for prescribing, which was comparable to similar practices. The practice worked with the CCG to review their prescribing to achieve value for money. This identified whether the practice was using the most cost effective medicines. Regular liaison took place and the practice was informed when a more cost effective version of a particular medicine was available and they were able to change their prescribing process accordingly.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

One GP told us how the practice maintained a register of patients with depression and a register of patients who had severe mental health needs. These patients were monitored by the GP lead for mental health. This ensured that all patients with depression and severe mental health needs were offered appropriate annual health checks, their medicines were regularly monitored and any appropriate biochemistry checks were undertaken (the chemical analysis of blood and urine). The practice also screened all patients in at risk groups for dementia, for cognitive decline concerns. A read code was added to their electronic medical records to enable the clinicians to identify any future care or treatment needs.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child

Good

Are services effective?

(for example, treatment is effective)

protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice manager and clinicians told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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 and for the implementation of preventative measures). The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, they professionally, and as a practice, reflected on their performance. Staff spoke positively about the culture in the practice.

The practice had a system in place for completing clinical audit cycles. We looked at ten clinical audits that had been completed. Following each clinical audit, changes to treatment or care were made where needed. Where relevant the audit was repeated to ensure improved outcomes for patients. For example, we looked at an audit investigating Atrial Fibrillation (AF), an abnormal heart rhythm characterized by rapid and irregular beating. The notes of patients with AF, who were not prescribed anticoagulation medicine (medicines that work to prevent the coagulation or clotting of blood) and who had other potential high risks, were searched to identify which of these patients may benefit from anticoagulation medicines.

The first audit undertaken in March 2014 identified patients with probable AF that were either currently being assessed by a GP or specialist, or who needed to be reviewed to see if anticoagulation medicine was required. Following the results of the first audit the patients identified for review were informed as were their respective GPs. The second audit in March 2015 again reviewed patients with probable AF. As with the first audit there was no evidence of undiagnosed AF with these patients.

There was a protocol for repeat prescribing which was in line with national guidance. 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. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the clinicians had oversight and a good understanding of best treatment for each patient's needs.

The practice worked towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided weekly long term condition clinics as well as family planning clinics incorporating sexual health and contraception services.

Effective staffing

We looked at records and spoke with staff and found that both clinical and non-clinical staff were appropriately trained and supported to carry out their roles effectively. All of the GPs had their own areas of clinical expertise which they were leading on for the practice and this enhanced the service they were able to provide to their patient population.

There was an induction programme in place for all new staff which covered generic issues such as fire safety and infection control. Medical students and GP trainees spent time within all areas of the practice during their induction. Staff described how they had shadowed other staff in the practice during their induction period so they became familiar with how the practice worked. We saw there was a range of non-clinical training for staff that was specific to their role such as training specific for reception or administration staff. There was a system in place to ensure staff received training that was considered by the practice to be mandatory, such as basic life support training, health and safety and safeguarding. Some training was delivered to staff through an online system and they received protected learning time (PLT) to enable them to complete it. Non-clinical staff were trained to carry out more than one role; for example, administrative staff could carry out reception duties to enable the practice to remain effective

Good

Are services effective?

(for example, treatment is effective)

during peak times. All staff underwent disclosure and barring checks to ensure their suitability for their role. We saw that all staff could access the practice policies and guidance electronically from the practice intranet.

The GPs and the nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies. The GPs were up to date with their yearly continuing professional development requirements and were revalidated in March 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

We found that staff received an annual appraisal, supported by the practice manager, where their learning needs were identified and they had the opportunity to discuss their work. Their annual activity was objective driven with a personal development plan, agreed at each appraisal and we saw examples of these plans in staff files.

Practice nurses and the healthcare assistant 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 asthma, hypertension and diabetes. Staff told us the practice was very supportive of training, for example one nurse was undertaking a certificate in diabetes care at Warwick University, to support diabetic care at the practice.

The practice was a training practice and supported the training of medical students throughout all years of their training at the practice. This included foundation year doctors and specialist or general practice training doctors who were training to be qualified as GPs. We saw that students were provided with a workload appropriate to their level of training and underwent review and debriefing with a senior GP following all their appointments sessions. Extended appointments were provided and students had access to a senior GP throughout the day for support.

We saw there was a process in place to manage poor performance of staff members.

Working with colleagues and other services

The practice worked with other service providers to meet patient's' needs and manage those of 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to the 'duty doctor' for that day. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan. There was a comprehensive system for managing results and discharge summaries and updating patient records and repeat medicines.

The practice held monthly multidisciplinary team (MDT) meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, senior nursing staff from local nursing homes, social workers, palliative care nurses and decisions about care planning were documented in the patients' care record. The practice also held monthly meetings with health visiting team to discuss concerns regarding any families and children on the child protection or child in need register. We saw minutes of meetings where teams had discussed future care requirements for patients with complex needs. Staff we spoke with told us this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Good

Are services effective?

(for example, treatment is effective)

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Two GPs were accredited trainers with Cambridge University, with one GP an associate trainer. The practice provided training for students from all stages of the Cambridge University undergraduate scheme.

We also saw how the practice spoke with and worked collaboratively with hospitals and consultants to the benefit of its patients. The practice provided designated rooms within the building for outreach services, such as ultra sound scanning for patients of both the practice and neighbouring practices. Midwifery services were available three times a week with access to a specialist midwife for very young mothers. There were also Improving Access to Psychological Therapies (IAPT) services available for patients at the practice, with both low intensity and high intensity therapists holding sessions at the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

There was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

A consent policy was in place that identified the different types of consent that could be obtained including implied, verbal and written. We found that clinical staff were aware of the Mental Capacity Act 2005, however not all staff told us they had received training. Staff were also aware of 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.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). Staff we spoke with were able to give examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. The practice also followed the correct procedures when considering making do not attempt resuscitation orders. This involved support for patients to make their own decisions and how these should be documented in the medical notes.

Clinical and reception staff we spoke with were aware of the consent issues known as Gillick competence. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).They understood 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 we spoke with were aware that they then had to apply the Gillick competency test. 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.

Patients we spoke with on the day of our visit told us that they were provided with sufficient information during their consultation and that they had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

All staff we spoke with were familiar with the importance of patient consent. We saw evidence of the learning in place

Good

Are services effective?

(for example, treatment is effective)

within the practice following a complaint relating to access to a patient's medical records by another health provider. We saw the practice had undertaken information governances training and had protocols in place for future requests.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Staff showed us and told us about the new patient's registration pack which included a new patient health questionnaire, a patient ethnic origin questionnaire, a medication information questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved.

We noted a culture among all clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, patients who smoked were encouraged to see a practice nurse who had received training to support those who wished to give up smoking. The practice identified patients requiring additional support. They kept a register of all patients with a learning disability with a lead nurse offering annual health checks and their on-going treatment was followed up by the practice. Care plans in place were regularly reviewed. We saw the practice achieved a high level of accurate recording for dementia diagnosis achieving 84% diagnosis rate, this being 7th out of the 106 practices within the CCG area. The practice had achieved 85% of annual health checks for this group of patients.

The practice offered all women six week postnatal checks with a GP and childhood immunisation clinics. We saw the practice had achieved 90% uptake for childhood immunisations. Family planning services were available for patients with trained GPs and nurses and the practice also provided contraceptive coil and implant fitting.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. Cervical screening was coordinated by a named member of staff and the practice had achieved 80% uptake for cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients through posters in the surgery the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available. There was a clear policy for following up non-attenders.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included Chlamydia screening for 16-24 year olds and advising patients on the effects of their life choices on their health and well-being. The practice worked closely with the patient representative group to organise regular health promotion talks with guest speakers and representatives for patients and the public. These included topics such as osteoporosis, palliative care, carers and a healthy diet.

The practice proactively identified patients, including carers who may need on-going support and were able to demonstrate access to local mental health services. The practice offered signposting for patients and their relatives and carers to organisations such as carers support groups, the Alzheimer's society and Help the Aged.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 National Patient GP survey and a survey of patients undertaken by the practice's patient reference group (PRG) in November 2014. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 331 surveys to patients, there had been a 37% response rate. Results showed the practice was rated in line at 89% for patients who rated the practice as good or very good in comparison to the CCG average of 86%. The practice was also above average for its satisfaction scores on consultations with GPs and nurses with 93% of practice respondents saying the GP was good at listening to them, 90% saying the nurse was good at listening to them, 96% saying they had confidence and trust in the last GP they saw with 97% saying they had confidence and trust in the last nurse they saw. The PRG recorded 99% of patients who responded to the 2014 survey considered that the GPs and nurses treated them with respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards. Eight were very positive about the service experienced. However we received some less positive feedback on 17 comment cards which we raised with the practice at the time of the inspection, they were aware of the issues of concern and were monitoring the situation. Patients said they felt the practice offered an excellent service and staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection, they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We noted the practice self-monitoring blood pressure machine was positioned away from public view for patients to use privately.

The practice had a range of anti-discrimination policies and procedures that staff could access via the electronic intranet system. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. However not all staff had a good understanding of the Mental Capacity Act. We discussed this with the practice manager who agreed to review all staff training in this area.

The results from the 2015 National Patient GP survey which we reviewed showed that patients' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 94% of practice respondents said the GP was good at explaining treatment and results and 87% that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed

Good

Are services caring?

decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand.

Staff told us that translation services would be made available for patients who did not have English as a first language. An electronic appointment check-in system, was available to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

There was a range of leaflets and posters in the practice's waiting room, giving patients good information about local support and advocacy groups whom they could contact for additional support. There was a dedicated notice board in the waiting area for patients with caring responsibilities informing them of various avenues of support available to them. The practice's computer systems had an alert to identify patients with caring responsibilities. The practice worked closely with a local nursing home as the lead GP practice. A GP attended for twice weekly ward rounds from 8.15am to 11am, where each of the four units were visited to assess patients physical and mental health care needs

There were regular monthly multi-disciplinary meetings attended by the senior nurse from the nursing home and the local palliative care team to ensure that important patient information was shared and joined-up care planned for those at the end of their lives. When the practice was notified of a patient's death, it was recorded on a discreet notice board in the administration area for information and a system was in place to ensure that all relevant agencies were informed of the patient's death. The patient's regular GP would then decide if it was appropriate to visit the family or for the practice to send a supportive letter of condolence to their relatives.

Staff we spoke with had a good knowledge of a range of local counselling and support agencies, and regularly referred patients to them when needed.

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 patients' needs and had sustainable systems in place to maintain the level of service provided. We found that the practice understood the needs of the patients using the service and the services were tailored to patients' needs to ensure flexibility, choice and continuity of care. The practice held information about the prevalence of specific diseases; this reflected the level of service provided. For example, reviews of the cervical screening programmes, patients with long term conditions, flu and pneumococcal vaccinations and childhood immunisations. There were systems in place to contact patients who failed to attend for screening programmes and immunisations. Patients were invited to attend for health checks and flu vaccinations.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Patients could request to see a GP of their choice and this was accommodated on most occasions. The practice held 2.4% of its most vulnerable of admission, older patients on an 'unplanned admissions' register'. One GP told us the practice aimed to call these patients back within 30 minutes of a home visit request or for any urgent medical problems. Practice audits showed the practice had achieved a 92% call back rate within 30 minutes for these patients. The practice then aimed to provide a home visit by a GP within two hours of the call back. Home visits were also available for older people, those with long term conditions and those with limited mobility. We saw the practice had visited 44% of patients within two hours of a request for a home visit, with 94% of requests for home visits to older and vulnerable patients visited by a GP on the same day.

Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. We saw the practice contacted all patients on the unplanned admissions register on the day following any contact with the out of hours service or following discharge from hospital to review and undertake any follow up care or treatment.

Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues.

Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed. Those patients responding to the last national GP patient survey 92% stated the GP gave them enough time, with 96% stating the nurse gave them enough time.

Patients were able to request repeat prescriptions on-line, by email or to attend the practice personally. Prescriptions were ready within 48 hours, but patients we spoke with told us that they were often ready for collection earlier. The practice offered flu vaccines to patients over 65 and to those who met the current health criteria. We saw the practice had achieved a 77% uptake for flu vaccines with an additional 14% of patients who were offered the vaccine, but declined.

The practice had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss patients and their families care and support needs. Patients could be referred to this group by any health professional in the practice who had recognised a chronic problem or recent rapid deterioration that may benefit from the close attention of the team members, such as; the GPs, social workers, community matron, mental health workers and other local voluntary organisations.

The practice was awarded the 'Practice of the Month' in September 2014 for their work with carers, in particular the drop in service set up by the practice, the practice had worked closely with the Carers trust to run drop in sessions for carers where they could come to the practice, have a cup of coffee or tea and speak to someone for support and advice (the carers trust provide cover for carers to facilitate a short break or evening off and provide signposting for additional help and support). The practice manager told us there were no other services of this type in the area and the Carers Trust had recognised the practices innovation in working with them on this.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services. One GP partner showed us data from the local CCG of the practice's performance for A&E attendances,

Good

Are services responsive to people's needs?

(for example, to feedback?)

which were slightly above average for the locality. The practice was located near to the the local hospital which it was felt may have been a contributory factor. However the practice had put systems in place to reduce A&E attendance during practice opening hours, this included a new telephone system with a call monitoring board to audit all incoming calls and response times. In addition the practice was moving towards a GP telephone triage appointment system from 1 June 2015 which it was felt would offer a more responsive and safer appointment system. The practice manager told us they would be monitoring its effectiveness.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of patients living with dementia. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review. Moreover, we saw that the practice ran regular checks of the data on their patient record system to identify patients with a range of factors that were particular indications of a learning disability or of dementia so that they could benefit from this service.

We also saw that the practice was configured in a way that enabled patients in wheelchairs to access their GP. There was level access throughout with widened doorways and accessible toilets. The practice had a hearing loop installed in reception and a system in place to support patients with reduced hearing when telephoning the practice. We saw that the practice's web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information in over 80 languages about the practice and about NHS primary medical care. The practice had access to online and telephone translation services and double appointments were offered to patients who required an interpreter. One member of the reception team was fluent in both Polish and Russian and was able to support patients with these as a first language when required. Patients who were not permanent residents could access the service by either registering as a temporary resident or if their need for medical treatment was immediately necessary.

Access to the service

The practice was located in a purpose built surgery with a recent extension. There was a ramp to access the surgery with automatic doors. All consultation and treatment rooms were on the ground floor.

The practice was moving towards a GP telephone triage appointment system. Appointments were available daily from Monday to Friday in the morning and afternoons. Patients could also register to book telephone consultations on-line. We were told that patients were offered an on-the-day appointment where necessary. This system provided more GP patient 'over the telephone' consultations which in some cases meant the patient did not need to attend the practice. Patients telephoned the practice and were asked for brief information about why they needed to see a GP; a GP would then telephone the patient back. Where patients were unable to take a call due to work or family commitments they could specify a convenient time for the GP to call. The GP would then schedule a call for example during the patients coffee or lunch break or when home from the school run. Where a telephone consultation was not sufficient, an appointment was then offered for the same day. The GP would determine the length of the appointment according to the patients' needs. Patients did not have to telephone the practice before a certain time in order to access an 'on the day' appointment. All calls made throughout the day were actioned in the same way or referred to the duty GP.

The practice was open Monday to Friday from 8am to 6pm with a duty doctor available Monday to Friday until 6.30pm. In addition the practice offered extended hours appointments to suit working people at variable times and days during the week. Weekday's mornings from 7am to 8am or evenings 6.30pm to 8pm, or Saturday mornings from 8am to 11am. These were only available to be pre-booked and not on the day. The availability of this service was displayed in the waiting area and on the website. Information for urgent care was available from the practice website and was additionally displayed inside the waiting area. Telephone consultations were carried out by the duty GP. The patient was able to discuss their concerns with the GP on the telephone and where necessary the GP would provide an appointment on the same or on a more appropriate day.

We saw evidence that the GPs fully engaged with the local emergency care centre to appropriately triage patients. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

saw through the use of the same day appointments, telephone consultations and the availability for home visits, that patients had a range of options to access services. Patients were able to sign up for electronic communication, which allowed them to request repeat prescription and electronic prescriptions to their nominated pharmacy. GP appointments were also bookable online.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external provider contracted by the clinical commissioning group (CCG). Details of how to contact the out of hours provider were available on the practice website as well as in the practice.

We spoke to four patients, three who told us they did not have an issue getting an appointment and they were always able to get in the same day they needed to. A survey of patients undertaken by the practice's patient reference group (PRG) in November 2014 showed that 93% of patients who responded to the survey were aware that appointments and prescriptions could be accessed on-line and 94% responded they were able to get an emergency appointment with a GP or nurse when they needed one.

GPs provided two ward rounds twice a week to a local 106 bed nursing home as well as attending the home for any urgent patient medical needs.

Repeat prescriptions were dealt with on the same day by a dedicated member of staff; we saw this process in place together with effective steps being taken when these were collected. The process was robust and ensured timely issuing of repeat prescriptions with adequate security on collection.

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.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We saw that complaints recorded in the last 12 months had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We looked at the most recent complaints the practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff.

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 intranet carried their vision statement which was centred on providing the highest quality healthcare. This was reflected in the practice's statement of purpose they had submitted to the CQC as part of their registration responsibilities with the principal aim stated as 'To provide prompt excellent and evidenced based care in a safe, caring and confidential environment to all the practice population'. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

It was evident from our interviews with the management team, the GPs and the staff, that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that put outcomes for patients first. Throughout our visit we saw a consistently kind, caring and compassionate approach to patients that supported this assertion.

Governance arrangements

The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice policies and procedures were available to staff on the desktop on any computer within the practice. We saw the policies and procedures had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, GP partners were leads for adult and children safeguarding and governance and there was a lead nurse for infection control. The staff we spoke with were all clear about their own roles and responsibilities. We were told they felt valued and well supported. Staff knew who to go to in the practice if they had any concerns.

The practice used the Quality and Outcomes Framework (QOF) and data from the Clinical Commissioning Group (CCG) to measure its performance. The QOF data for this practice showed it was performing above the local CCG and national average in all indicators. With a 93.9% achievement across clinical indictors. We saw that QOF and CCG data was regularly discussed at the team meetings and action agreed where necessary to maintain or improve outcomes.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used and were effective. For example there were processes in place to frequently review patient satisfaction and that actions had been taken where appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example health and safety and fire safety. The practice monitored risks on a regular basis to identify any areas that needed addressing and documented the findings.

The practice had completed clinical audits cycles which it used to monitor quality and systems to identify where action should be taken. For example the practice was undertaking audits for the prescribing of antibiotics (medicines that fight infection). This ensured there was a reduction in prescribing of these medicines; they were using these medicines in line with clinical guidelines which were safer for patients and were using the most cost effective treatment available.

The practice held quarterly evening staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included the induction policy and job descriptions which were in place to support staff. The staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. However not all staff we spoke with were aware of the practice business recovery plan, though were able to locate it on the practice intranet when asked.

Staff told us that there was an open culture within the practice and they had the opportunity to raise issues during their appraisals and at team meetings, they also told us

Are services well-led?

Good

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

they felt confident to raise issues. We saw evidence from minutes of team meetings where issues were raised by staff and evidence where action had been taken. These meetings took place in a formal, arranged format, however the practice manager told us that until recently not all nurse meetings had been minuted. We saw that minutes of nurse meetings were now recorded and circulated to staff.

All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

We noted that staff were positive in their attitudes and presented as a happy workforce. They told us they felt supported and valued. We considered this to be evidence of the effectiveness of the leadership approach adopted by the practice.

We saw that the practice had an active and engaged patient representative group (PRG) to promote and support patient views and participation in the development of services provided by the practice. For example as a result of feedback from a PRG patient survey, the practice had changed the entrance doors to enable safer and easier access to the surgery.

We looked at results of the latest national GP patient survey which showed that patients would recommend the practice with 88% responding positively, as opposed to a local CCG average of 81% and a national average of 79.1%.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients by distributing cards from the NHS friend and family test as well as patient surveys. We saw evidence on the practice website of the results of these surveys which were available for the public to view. We looked at the results of the annual patient survey and 72% of those that responded stated they found it easy to get through to the practice on the telephone. In order to improve this level of satisfaction, the practice had introduced a new telephone system and was introducing telephone consultation appointments from 1 June 2015.

The practice had an active patient representative group (PRG) and continued to promote recruitment to the group. There was information about joining the PRG and the work they undertook on the practice PRG notice board and website. We saw the PRG had carried out annual surveys and met at regular intervals, we were told a GP was present when they met. The practice manager showed us the analysis and action plan from the last patient survey, which was considered in conjunction with the PRG. As a result of these surveys the practice had also improved the telephone system and with the PRG had consulted with the local council to improve road safety on the approach to the practice car park entrance. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and extended this training to medical students from the local university at all

Are services well-led?

Good

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

stages of their degree. We were told that the nurses conducted their own training and we saw evidence of continuing professional development in the files of the clinicians we reviewed.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.