

The Practice South Woodham Ferrers

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Practice, South Woodham Ferrers on 06 March 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. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance. 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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had facilities that were well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on. There was a very active, well supported patient reference group that was consulted about improving services.

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?

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. Staff had received safeguarding training and understood the reporting procedures. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Medicines were stored correctly and monitored for expiry dates.

Good



Are services effective?

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. Patient's 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.

Good



Are services caring?

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 said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients know about the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Carers were identified and support offered to them.

Good



Are services responsive to people's needs?

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) to secure improvements to services where these were identified. Patients were generally satisfied with the appointment system but were sometimes kept waiting in reception before seeing the GP. Patients received continuity of care and could mainly obtain an appointment with their GP of choice. Urgent health issues were

Good



Summary of findings

prioritised with appointments available the same day. A duty doctor system was in place and effective. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

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 clear about the vision and their responsibilities in relation to this and their job roles were linked to it. There was a clear leadership structure and staff felt supported by management. Area and regional managers provided support and monitored performance from a corporate perspective. 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 reference group (PRG) was very active and well supported by clinical staff and area managers. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of older people. All patients over 75 had a named GP. Carers were identified and offered support. Home visits were available to those patients who were house bound. A community phlebotomy service, undertaken by the health visitors at the practice, was available so elderly patients could have their blood taken in their own homes. 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. Staff were trained in safeguarding procedures in relation to the elderly and vulnerable and knew the different signs of abuse.

Good



People with long term conditions

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. Annual reviews took place of their medicines and their general health. Some nursing staff had received specialist training in respiratory care and diabetes management. Patients with diabetes received additional support using an individualised care and management plan. Health care assistants provided a phlebotomy service including monitoring patients on blood thinning medicines. Smoking cessation advice was available. Patients identified as at risk of deteriorating health were monitored to reduce the risk of hospital admission. Patients who did not attend for appointments or reviews were contacted to ensure they were fit and well. Multidisciplinary team working took place with other healthcare professionals to provide the right care and treatment and a package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. A community midwife attended the practice each week to hold antenatal clinics. Childhood immunisations were available twice each week via an appointment. Immunisation rates were relatively high for all standard childhood immunisations. The nurses and GP carried out six/eight week baby checks. Family planning advice was available including the fitting of contraception devices. There was liaison with a local secondary school to provide contraceptive advice. Staff were trained in safeguarding procedures in relation to children and young persons. Flexible appointment

Good



Summary of findings

times were available so that children could be seen outside of school hours. We saw good examples of joint working with midwives, health visitors and school nurses. Staff were aware of Gillick competence in relation to 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 early appointments on some mornings. Patients could book appointments on-line. An open surgery, when appointments was not required, ran daily offering flexibility. Saturday morning flu vaccination clinics were available in the winter months. Health screening was available for patients to identify any healthcare issues and opportunities for prevention. Lifestyle advice was available for patients.

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 so they could be regularly monitored. Annual health checks took place or earlier if required. Longer appointments were available so that issues could be discussed and understood. The facilities at the practice 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. Vulnerable patients and/or their carers were signposted to various support groups and voluntary organisations. 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 including mental health crisis and counselling teams. Mental health counselling was available weekly. Longer appointments were available when necessary. Patients with dementia were supported by the practice. They were given an annual review of their health and care needs. There was liaison with the local dementia care services so that patients could be monitored in their own homes. The practice endeavoured to see

Summary of findings

dementia patients on time to reduce anxiety and stress to them caused by waiting. 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, patients were invited to complete comment cards about their views of the practice. We collected 29 cards that had been left for us and reviewed the comments made.

The majority of the comment cards we viewed contained complimentary comments about the GP, nurse, reception staff and the services provided. Patients commented that staff generally were kind, caring and supportive. A few negative comments were made in relation to appointment availability and the time patients were kept waiting to see the clinical staff.

We spoke with four 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. Patients did not feel rushed during consultations and they said staff were kind and caring. They told us that explanations were clear and care and treatment was delivered to a satisfactory standard.

The latest patient survey reflected that patients were generally satisfied with the services they provided but some areas for improvement had been identified which were the subject of an action plan.

The patient had an active patient reference group (PRG) that worked with the practice to discuss areas for improvement. This included face to face meetings and a virtual group of 170 members whose views were sought by email. Regular meetings took place and they were kept informed about developments. The PRG was well supported by the practice with GPs in attendance. Information was updated on the practice website. PRG members and patients were given the opportunity to provide feedback about the services provided and contribute ideas for improvement.

The Practice South Woodham Ferrers

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor.

Background to The Practice South Woodham Ferrers

The Practice South Woodham Ferrers is situated in South Woodham Ferrers, Essex. The practice is one of 48 GP practices in the Mid Essex Clinical Commissioning Group (CCG) area. The practice has an alternative provider medical services (APMS) contract with the NHS. There are approximately 5100 patients registered at the practice. The practice undertakes minor surgical procedures.

The practice has four GPs working at the practice, three of which are salaried. One GP is the designated clinical lead. There is a mixture of male and female GPs. The GPs are supported by four nurses, two of them being nurse practitioners. There is also one health care assistant. There is a practice manager and an assistant practice manager and a team of reception and administration staff who undertake various duties.

The surgery is open Monday to Friday between 8am and 6.30pm on Monday to Friday with a late evening surgery on Wednesday until 8.45pm. Surgeries run in the mornings and afternoons each day. The practice is closed at weekends but open on Saturday mornings in the winter period for flu vaccinations. The practice has opted out of

providing 'out of hours' services which is now provided by another healthcare provider. Patients can also contact the emergency 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.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is 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.

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?

Detailed findings

- 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)

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 March 2015. During our visit we spoke with a range of staff including two GPs, two nurses, the practice manager and assistant practice manager, reception and administration staff. We spoke with patients who used the service and a member of the patient participation group. We observed how people were being cared for and talked with carers and/or family members 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 we viewed them afterwards.

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 alerts were reviewed by the clinical lead who was one of the GPs. Where action was required this was undertaken in a timely fashion. The alerts were cascaded to other clinical staff through their internal communications system and appropriate action was seen to have taken place.

We spoke with six members of staff on the day of our visit who were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. A computerised reporting system was in place and staff were encouraged to use it and to grade incidents according to their risk. Notifications of such incidents were automatically sent to the practice manager to review and action.

We reviewed significant events and complaints for the last 12 months and found that they had been investigated, analysed and learning identified. Action had been taken to reduce the risk of reoccurrence. Staff spoken with were aware of safety incidents that had occurred and confirmed that these had been discussed with them at regular team meetings. Minutes of these meetings had not been routinely completed. The practice told us that they were aware that this was an improvement area and that future meetings would be minuted more efficiently.

The practice was able to assure us that safety issues had been managed consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There had been 19 significant events in the last 12 months and we reviewed a sample of these. We found that they had been recorded, analysed, investigated and actions implemented where necessary.

Significant events and complaints and the learning from them was discussed at monthly staff meetings and monitored for common themes and trends. Although the minutes of staff meetings had not been recorded we found that staff spoken with were aware of the incidents that had

occurred and understood the learning from them. We saw evidence that the practice was already aware that minute taking at meetings required improvement and this was being actioned.

A staff meeting was held monthly and all staff were required to attend. This included the GPs and the nursing staff. Management meetings were also held where significant events and complaints were discussed so that there was oversight of any issues that had occurred. There was evidence that the practice had learned from these. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and were required to grade them in relation to the risk they presented. These forms were then automatically sent to the practice manager and the head office. This generated a monitoring system that required the appropriate action to be taken within set timescales and managers were sent reminders to ensure that incidents and complaints were investigated and analysed in a timely fashion. We found that there was an effective system of monitoring reported incidents and that safety issues were prioritised. There was also clinical oversight of such incidents.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were analysed and actioned by the lead GP who disseminated them to relevant staff. The GPs we spoke with confirmed the system in place and displayed knowledge of alerts that had been received and relevant to their area of responsibility.

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.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic record system through the use of coding. This included information to make staff aware of any relevant issues when patients attended appointments so they could

Are services safe?

be easily identified and offered additional support. The lead safeguarding GP was aware of those patients identified as vulnerable children and adults and was monitoring and reviewing them.

We found for example, an incident where the practice had taken appropriate action to promote the safety of a child they considered may be at risk.

We looked at training records which showed that all staff had received relevant role specific training in safeguarding procedures. We spoke with several members of staff on the day of our inspection and found that they had received online training and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details of external organisations and a guide to safeguarding had been placed in a prominent position on the walls of each room at the practice to support staff.

There was a chaperone policy and a system was in place to ensure that staff had read 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). Staff were required to read it and sign to show that this had been completed and the policy understood. We found that all relevant staff had signed it. Chaperone signs were displayed in the waiting room and consultation rooms for the information of patients.

Chaperone duties were undertaken by the nurses, health care assistant and some members of reception staff if a clinical staff member was unavailable. We spoke with a number of staff members who had undertaken chaperone duties. Some had attended formal training and some had received awareness training from the lead GP or nurse. We found that the staff we spoke with were aware of the responsibilities of a chaperone and where to stand during a consultation. They told us that they were always in view of the patient and could see any examination clearly. This protected both the GP and the patient. Patient records were updated to reflect that a chaperone had been in attendance at the consultation.

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, which described the action to take in the event of a potential failure. 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.

The practice had made arrangements with a local pharmacy so that patients could collect their dispensed prescriptions at a local chemist and to order repeat medicines from the practice via the chemist or by email request. Information about this was available to patients at reception, in the practice leaflet and on their website.

Cleanliness and infection control

The practice had a lead for infection control who had received appropriate training. An infection control policy had been read by all staff working at the practice and they had signed to show that this had been undertaken and the policy understood.

Infection control training had been received by staff if relevant to their role. Other staff had received hand washing guidance so they understood the appropriate technique to reduce the risk of infection. This included having to demonstrate their understanding of the technique to a qualified member of staff. This was noted in their personal file.

Are services safe?

An infection control audit took place annually and this had been completed to a satisfactory standard. Where areas for improvement had been identified these had been actioned in a timely manner.

We saw that cleaning schedules were in place and cleaning records were kept. A cleaning contractor had been appointed to undertake the cleaning of the general 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. The quality of the cleaning was monitored by the practice manager and infection control lead.

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 every six months.

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.

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 waste was being stored correctly and an external contractor collected it regularly.

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 records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

We did find however, a number of single use items of medical equipment, used when undertaking minor procedures on patients that were past their expiry date.

The practice agreed to take them out of use immediately and to replace them. They also agreed to review their monitoring system in use for these and other instruments in use at the practice.

Equipment

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 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 weighing scales, spirometers, blood pressure measuring devices and blood/sugar testing equipment for patients with diabetes.

We found that when staff reported shortages of equipment this was actioned by the practice manager and supported by the head office. One such example was in recent months when it became apparent that an auroscope (used for ear examinations) was being shared amongst clinical staff and this was unsatisfactory for patients as it often caused delays. As a result it was agreed that several new items would be purchased, including a spare and consequently all clinical staff had their own device.

Staffing and recruitment

We did not look at recruitment processes on the day of this inspection as these had been reviewed recently at a separate inspection in February 2015. At the time of that visit we found that robust recruitment processes were in place including 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.

The practice manager planned and monitored the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place to ensure that enough staff were on duty that were qualified to meet the needs of

Are services safe?

patients. Seasonal variations in demand had been assessed and additional staff made available during the winter flu season. This included additional GPs and reception staff to deal with the increased demand.

There were a number of staff members who shared job roles on a part-time basis and covered for each other at times of annual leave. This did not impact on the effectiveness of the practice as they worked as part of a team and supported each other. Staff training was monitored and reviewed to ensure the right mix of skills and experience supported the patients.

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.

However when we viewed comment cards that had been completed by patients prior to our inspection we found that several patients had commented about being unable to get appointments when they needed them and delays on occasions of 30 minutes to an hour after their allocated appointment time.

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. Monthly checks of the building and the environment took place and staff were encouraged to report any maintenance issues that presented a risk.

There was a system in place to respond to risks identified at the practice in relation to faulty equipment or fixtures and fittings. A local maintenance company were contacted and they attended promptly to carry out repairs. Where the cost of the repairs exceeded a certain amount, authority from head office had to be sought but this was granted in a timely manner.

A clinical risk assessment had identified that infection control audits had not been completed at the required intervals. This had been rectified and they were now conducting them in line with guidance from the Department of Health.

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

Patients suffering from conditions making 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

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was 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). The chest pads used with the defibrillator were in date and available for children and adults.

Emergency medicines and equipment were available in a secure area of the practice and all staff we spoke with knew of their location. We checked the equipment available and found that it was of the recommended type and variety. 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 of the recommended type.

Staff working at the practice were required to undertake online training in fire emergency procedures. They had to achieve an 80% pass mark and this was monitored by the practice manager. Fire alarm servicing had been undertaken in February 2015 and the equipment was found to be in working order. A fire drill protocol was in place and fire extinguishers were in date and suitably placed allowing easy access for staff.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included power failure, adverse weather, unplanned sickness and access to the building. 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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with three GPs, a nurse and a health care assistant 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. Staff had ready access to the guidelines through their local intranet and could refer to them when necessary.

There was an effective system in place to monitor national patient safety and medicines alerts. These were sent to the practice and reviewed by the GP who made appropriate clinical decisions. The information was then disseminated to the nurse and other staff if relevant to their role. This included undertaking audits of patients on the medicines identified as being potentially unsafe then conducting a review as to whether they should continue to be prescribed or an alternative offered. This ensured patients received effective consultations and treatment.

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. Registers were in place and other healthcare professionals were involved in assessing their needs. Patients and their carers/families were signposted to support from external organisations, such as Macmillan nurses and health visitors.

Where an 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. We were told by staff responsible for the referrals that the system was effective and patients were referred in line with national timescales.

The practice had recently reviewed the way they supported patients with diabetes and had introduced a more efficient monitoring system. This involved a more individualised approach to the condition and patients were invited in to the practice to establish better methods of managing their condition. This meant a reassessment of their needs. Advice and guidance was given to them by clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had recently employed a new member of staff whose responsibility was to monitor the practice performance under 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.

The practice had recognised that the QOF performance to the year end of March 2014 required improvement in relation to the management of patients with diabetes. As a result of this a new member of staff was now responsible for monitoring the practice performance across all key areas. Monthly performance meetings were now being held where staff were updated about the performance across the practice in the areas measured. This was also monitored by the area/regional managers. Current data reflected that improvements were being achieved and there had been steady month on month progress.

One initiative they had introduced was a personal diabetes health and wellbeing compass. The overall aim of this initiative was to improve the day-to-day care of people with 'type two' diabetes through applying a flexible approach to managing the condition. Patients with 'type two' diabetes were seen and the procedure explained. It covered a range of support and advice including well-being, support networks, self-care and clinical care. As this was a new initiative the benefit to patients had not been able to be measured but evaluation will follow.

The practice also used the information collected for the QOF to compare their performance against national screening programmes to monitor outcomes for patients. The most recent data up to March 2014 reflected that they had achieved their target for the national programme of child vaccinations and in some areas had achieved 100%. This was higher than the local Clinical Commissioning

Are services effective?

(for example, treatment is effective)

Group (CCG) average. They had also achieved their targets in relation to cervical screening, maintaining registers for patients with learning disabilities and dementia and the monitoring of patients suffering from poor mental health.

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

The practice had implemented 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.

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.

The IT system in use at the practice highlighted 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 GPs had oversight and a good understanding of best treatment for each patient's needs.

A number of audits took place at the practice to ensure care and treatment was effective. One such audit related to consultations by the GPs where a sample of patient records were checked to ensure they were being conducted efficiently. Areas for improvement were identified and actioned. Other audits included infection control and diabetes monitoring.

Appropriate audits had also been carried out in relation to alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). This involved 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff training was being monitored to ensure they were up to date with attending relevant courses such as annual basic life support. The practice had recently appointed a new practice manager and up until this time the monitoring of training had fluctuated and consequently some training was overdue. This had been recognised by the new practice manager and steps had been taken to make improvements in this area. A system was now in place to notify staff of their training requirements and to effectively monitor and ensure that it was being undertaken.

The practice manager and deputy manager that we spoke with felt supported by the lead GP and the managerial staff at their head office. They said they could concentrate on undertaking their role and make changes when needed without unnecessary referrals for authority, although when this was required for a particular reason, requests were dealt with in a timely fashion and supported if they met the needs of patients or staff.

We were told that the locality business lead for the main organisation attended the practice regularly to hold meetings with the practice manager and this provided the necessary support required. Where required, training requests were met and advice and guidance was readily available.

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).

The lead GP assumed responsibility for monitoring the performance of the other GPs at the practice and this included the completion of induction checklists when they first started working there. Records we viewed reflected that the competency of GPs was being assessed and recorded on an annual basis in addition to the revalidation every five years.

Are services effective?

(for example, treatment is effective)

All other clinical and non-clinical staff received annual appraisals that identified learning needs from which action plans were documented. Staff were set objectives and their performance was monitored throughout the year and they were given gradings to reflect their achievements.

Staff spoken with had all received appraisals and felt they were fair and meaningful. They told us that development opportunities were discussed with them and that the practice was proactive in providing training and funding for relevant courses where it met the needs of patients.

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.

Working with colleagues and other services

The practice worked with two local care homes. They were visited by the GPs and the nurse working at the practice. We were told that there was a positive relationship between the practice and the care homes and that reviews of patients with dementia and learning disabilities took place in them. They also undertook a 'mini ward round' where patients living in the homes would be seen and spoken with to check on their health and well-being.

The practice worked with other service providers to meet patient's needs and support 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 information received by the practice was sent to the lead GP to assess the level of clinical input required before being transferred to the patient's record by a member of the administration staff. Where a follow-up was required patients were contacted by phone or letter and requested

to attend the practice so a review could be undertaken. Each GP was responsible for dealing with patient's letters and results and if they were absent from work a deputy was assigned so they were dealt with in a timely manner.

We spoke with two members of the administration team who told us that 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 the lead GP made it clear on records they had viewed, whether contacting a patient was routine or urgent and these were actioned appropriately.

The practice held multidisciplinary team meetings monthly for those patients with long-term conditions, end of life care needs or children on the at risk register. 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.

Patients requiring appointments with specialists were referred to a referral centre where their condition was assessed. This was to ensure that the correct clinical pathway was selected so that a patient received a consultation with an appropriate specialist. To ensure the practice was carrying this process out effectively, staff had visited the referral centre to observe how the process worked to give them a better understanding of the service. The visit confirmed that their own systems were in line with those being used at the referral centre.

We found that urgent referrals were being dealt with on the day and that other referrals were being effectively processed within usual two week timescales. A system was in place for tracking the referrals to ensure they had been completed.

Patients who were suffering from pressure sores and/or ulcers were referred to a tissue viability service that provided expertise on the management and treatment of them.

Information sharing

The practice used an electronic patient record system to record information about their patients. This coordinated, documented and managed patients' care. All staff were fully trained on the system, and commented positively

Are services effective?

(for example, treatment is effective)

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.

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.

Electronic systems were also in place for making referrals for patients who required specialist healthcare advice. The locally used system required a referral to be made to a central location where the most appropriate pathway was decided upon. Then patients received their referral. This usually took less than two weeks from the initial consultation with the GP to receiving an appointment date with a specialist. The staff we spoke with felt this was an efficient system that was working effectively and met patients' needs and expectations.

We saw evidence that a patient record audit had been carried out for each GP working at the practice to assess the effectiveness of the consultation and the completeness of the records. The lead GP had set standards that each GP was expected to achieve that were linked to effective consultations. The analysis and outcome of the audit was shared with each GP and formed part of their appraisal process. This helped ensure that patients received effective consultations.

A member of staff had been appointed to summarise patient records onto the computerised patient record system. The quality of the summary records had been monitored and as a result of increased support and training, we were told that the quality of them had improved.

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. Staff had signed this policy to indicate it had been read and understood.

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.

The GPs we spoke with were clear about mental capacity in relation to the assessment of a patient's ability to consent to receiving care and treatment. This included patients suffering from a learning disability or dementia where a judgement was required to be made on their mental capacity to consent. This included whether a decision was required to be made in their best interests. We were satisfied that correct procedures were being followed.

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.

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. They 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 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.

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.

New patients registering at the practice were offered a health check with the health care assistant / practice nurse.

Are services effective?

(for example, treatment is effective)

The GP was informed of all health concerns detected and these were followed up in a timely way. Health checks were also offered to patients aged between 35 and 74 and for those over 75.

We noted a culture among the GPs, nurses and reception staff to identify opportunities where patients could be offered a variety of health checks when attending for routine appointments rather than booking several different appointment times.

The lead GP had introduced a holistic way of supporting patients with 'type two' diabetes. In addition to the usual monitoring of blood/sugar levels and general health advice they had introduced a system where patients were provided with a range of guidance around managing their condition. A patient received a consultation with the GP or nurse who supported them to fully understand the condition. This encouraged patients to take ownership of their condition and improve their management of it through setting themselves targets and goals to achieve a better lifestyle.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG area, and again there was a clear policy for following up non-attenders by the named practice nurse.

Flu and shingles vaccinations were available for elderly patients or those with conditions that made them

vulnerable to the virus. Patients could also attend the practice for smoking cessation advice and smokers were identified through the patient record system and pro-actively contacted to attend the practice.

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 of the services available that were relevant to their individual healthcare needs and when they could attend.

This included support for diabetics and the management of their condition, smoking cessation clinics, asthma and chronic obstructive pulmonary disease (the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections). Details about the various immunisation programmes taking place were also sent to patients.

The practice had a register of patients in need of palliative care, suffering from dementia, those who were frail and at risk of their health deteriorating rapidly and for those with learning disabilities. Monthly multidisciplinary meetings took place where the care and treatment of individual patients was discussed. This identified the most appropriate care and treatment for them and allowed them to be treated in their own homes. Other healthcare professionals involved in this process included district nurses, social services and Macmillan nurses.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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.

We spoke with six 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 their 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. One member of staff we spoke with told us of the importance placed on confidentiality. They said they would always confirm the identity of the caller 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.

We reviewed data available for the practice on patient satisfaction by looking at the results of the most recent practice patient survey, held in February 2014, where 120 patients had completed questionnaires about the staff and the services provided. 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.

Information from the national patient survey from July 2014, reflected that patients were satisfied with the way they were treated at the practice. We found that 76% of patients found the receptionists helpful, 90% of patients found that the nurses at the practice treated them with care and concern and 84% said that the GPs gave them enough time.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

For example, data from the national patient survey showed 86% of practice respondents said the nurse involved them in care decisions and 83% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 77% of patients said the GP was either excellent or good at involving them in decisions about their care.

Patients we spoke with on the day of our inspection told us that health needs 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients who were elderly and vulnerable, those with long-term conditions or with complex issues were identified and recorded on a register. Their ongoing care and treatment was discussed with them and they were involved in the care and treatment decisions and plans.

The practice had implemented the Gold Standard Framework for managing the care and treatment needs of those patients requiring palliative care. This involved monthly multidisciplinary meetings with other healthcare professionals to identify patients support needs.

Patient/carers support to cope emotionally with care and treatment

Information was available on the practice website to provide patients with an explanation of the procedures to follow in the event of bereavement. Staff told us that if families had suffered bereavement, they were made aware of it so they could provide appropriate support when they attended the practice. This included a GP consultation if required or to signpost them to organisations that could provide support.

Are services caring?

Practice staff were pro-active in identifying those people with caring responsibilities and they were then offered advice, guidance and signposted to external organisations where further support could be obtained. The practice made carers aware of a local initiative that supported them. This was a Carer's Café, where carers could meet up and discuss good practice, receive support and meet in a social environment.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had sought suggestions for improvements in the way it delivered services in response to feedback from the patient reference group (PRG). This group was very 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.

Patients who were house bound were able to order repeat prescriptions by phone without the need to attend the surgery. Other patients completed request forms and left them in a box in reception, provided for that purpose or could order them online. They were dealt with within 48 hours.

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.

Antenatal clinics were held weekly with a midwife attending. Childhood immunisations were available twice each week 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. There was liaison with a local secondary school to provide contraceptive advice.

Systems were in place for older people to access the care they needed. Patients over 75 had a named GP and received continuity of care.

Services were provided so that the elderly were able to receive their annual flu vaccinations and there was a system in place to remind them when these were due.

Patients experiencing poor mental health had received an annual physical health check and longer appointments were available for this purpose. The practice worked with other healthcare professionals including mental health crisis and counselling teams. Mental health counselling was available weekly at the practice.

Patients with dementia were supported by the practice. They were given an annual review of their health and daily needs. There was liaison with the local dementia care services so that patients could be monitored in their own homes and provided with care and support. The practice endeavoured to see dementia patients on time to reduce anxiety and stress to them caused by waiting. Partnership working was taking place to support patients and their carers.

Patients with learning disabilities were identified and included on a register so they could be regularly monitored. Annual health checks took place or earlier if required. Longer appointments were available so that issues could be discussed and understood.

Patients we spoke with and comment cards we viewed reflected that the GPs and nurses always had time to listen to their concerns and they were not rushed.

Tackling inequity and promoting equality

Staff were required to undertake online diversity training and this was monitored by the practice manager. This helped staff understand the various cultural and religious beliefs on the patient population. Staff we spoke with confirmed that they had completed the training.

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 and parking was available for the disabled. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had access to online and telephone translation services for those patients who had difficulty understanding/ speaking English. Some staff at the practice also spoke a variety of other languages and were able to support patients.

Access to the service

Routine appointments were able to be booked up to eight weeks in advance for non-urgent matters. This often meant that a patient could see the GP of their choice more frequently.

Patients requiring to be seen sooner than the advance booking facility could book on the day. The system for the morning surgeries was to ring at 8am and for the afternoon surgeries to ring at noon. These were for GP consultations only.

The practice ran an open appointment system for on the day appointments that was primarily for emergencies. Patients could also see the practice nurse for the more minor illnesses and conditions. Patients could attend the practice to book in and wait to see the nurse. Children, the elderly and those who were vulnerable were given priority.

Each GP was allocated one reserved appointment time for each of their surgeries, to book in patients for follow-ups, rather than asking a patient to book at reception. This was useful for patients who required monitoring for a condition or illness that needed an early review. If this appointment was not used it was released for patients for an on the day appointment.

Each GP also had two appointments in the mornings and afternoons that were reserved for patients with emergencies and each GP was required to undertake phone consultations after each session.

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.

Longer appointments were also available for patients who needed them and those with long-term conditions or with learning disabilities. This also included appointments with a named GP or nurse. Home visits were available for those patients who were house bound or unable to get to the

surgery. A duty doctor system was in place to support this service. The practice's extended opening hours on Wednesdays until 8.45pm was particularly useful to patients with work commitments.

We were told that the results of a patient survey carried out by the practice in February 2014 reflected that patients were satisfied with this system. However feedback from CQC comment cards was varied about the appointment system in place. Some patients commented that it was difficult to get an appointment and that there was often a long wait to see the GP after their allocated time. One patient commented that this was common and had been as long as a 90 minute wait.

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. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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 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 more minor issues were also noted by staff that made the practice manager aware of them so that issues could be addressed and improvements made.

We found that the practice responded in a positive way to the complaints they received and investigated and analysed them effectively. Where appropriate apologies and explanations were given to patients and learning discussed with staff at team meetings. These were recorded on the meeting minutes.

Are services responsive to people's needs?

(for example, to feedback?)

We looked at five complaints received since January 2014 and found that they had been satisfactorily recorded,

handled and dealt with in a timely way. They were recorded regardless of whether they were of a minor or more serious matter. We found that the practice was open and transparent about the complaints they had received.

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 a clear vision to deliver high quality care and promote good outcomes for patients.

We found details of the vision and practice values were part of the practice's strategy and business plan. The practice vision and values included involving patients in decisions about their care and treatment, providing a consistently high standard of medical care and treating patients with dignity and respect.

We spoke with five members of staff and they all knew and understood the vision and values, knew what their responsibilities were in relation to these and how they were linked to their job description and role

Governance arrangements

The practice had identified lead roles for a number of staff at the practice. There were leads for infection control, safeguarding, and a clinical and palliative care lead. There was a practice manager and a deputy practice manager who shared the management of the practice on a daily basis. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

There was a system of governance by the owners of the practice from their base at their head office. Systems were in place to monitor the governance arrangements at the practice and these were regularly checked. Staff at the practice were required to complete governance activities within a set timescale and these were monitored and followed up by area managers.

The practice had a range of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice as part of their internal IT system. A paper version was also available to them if required. Staff were required to sign them to indicate that they had been read and understood. We found that the policies had been signed appropriately.

We looked at six of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy. All policies we looked at had been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The practice was owned by an organisation that also had several other GP practices. From a corporate perspective they had appointed area/regional managers who were responsible for the oversight of them and they set standards for all of their practices in their strategy. This included appointing a designated clinical lead at each location.

We found that a lead GP had been allocated the role of clinical lead at the practice and they met regularly with the area/regional manager to discuss issues and performance at the practice. The clinical lead told us that standards had been set for them which they were expected to follow and that they received support in achieving them. They said that they had implemented the procedures at the practice and they were the link between the head office and the practice.

The practice manager told us that the liaison between the staff, the lead GP and the head office was effective and that standards had been made clear to them. One such example was a monthly return that had to be completed that had to reflect that minimum standards, set by the organisation, had been achieved. This included the requirement to undertake a certain number of management and team meetings, completion of appraisals and performance monitoring.

A new practice manager had been appointed in January 2015 and the practice was going through a period of change, from the perspective of managerial roles and changes in GP staffing.

Staff spoken with told us that they had been through a period of uncertainty at the practice and that the leadership had improved considerably recently. They felt part of a team and were supported by the managers currently in place. They said they were involved in the strategy of the practice and were encouraged to offer ideas for improvement either informally or at practice meetings.

Are services well-led?

Good 

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

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had an active Patient Reference Group (PRG). This is a group of patients registered with a practice who work with them to improve services and the quality of care. On the day of the inspection we met with a member of the PRG.

We were told that there had been some problems experienced getting the support of patients who were able to attend meetings and that at the current time there were only approximately six patients who met regularly. However the practice, together with the PRG, had canvassed patients attending the practice and via their website and requested support for a virtual group. Those that volunteered contributed ideas by email and were kept updated of issues and developments. We were told that there were approximately 170 members. This had been achieved by putting up signs on a dedicated PRG notice board, advertising on their own website, invitations on prescription slips and personal invite letters.

Those able to, met every three months with the lead GP, practice manager and on occasions, the regional/area manager attended. We were also told that at one meeting the Chief Executive Officer of the organisation had attended to lend their support.

The PRG member we spoke with told us that the relationship with the practice was extremely positive. They felt that the practice was pro-active in seeking their views. They were able to provide areas for improvement and contribute to the planning of the patient survey. Feedback was also received from the virtual members and was discussed at the meetings. These were minuted and circulated to the members, by email to the virtual group, put onto the practice website and displayed in the reception area.

We were also told that representatives of the PRG had been invited to one of the staff meetings that had taken place to fully integrate them into the feedback process. Meetings also took place on a locality basis every three months where each local practice in the area would host a joint

meeting of all the practice PRGs to exchange views and ideas. This was then fed back into their own practices. In the near future the Clinical Commissioning Group was arranging a joint meeting for all PRGs in their area.

We were told that ideas were considered and acted upon. Some examples we were given where the PRG had been consulted about included the use of text reminders for appointments, the patient survey questionnaire, opening hours, the answerphone message and the viability of weekend opening.

Staff told us that they were encouraged to provide feedback and offer ideas for improving the services provided. This was achieved either informally. At staff meetings or during the appraisal process. We were told that there was a willingness to listen to their views and that they felt part of a team.

The practice last undertook a patient survey in February 2014 and we looked at the analysis and results of that survey. Patients were required to complete a questionnaire about the services provided and over 120 replies had been received. These included questions in relation to the appointment system, waiting times, availability of a preferred GP or nurse, explanations of care and treatment and whether patients felt involved in the decisions about their healthcare needs. There were many other areas covered.

One of the areas for improvement identified in the survey in 2014 was that 46% of patients indicated that they had been kept waiting for over 15 minutes to see the GP after their appointment time. Comments made on CQC comment cards tended to reflect the waiting time remains an issue. The provider should consider this when reviewing the results of the next survey and implement improvement processes if relevant.

The subsequent analysis revealed that patients were satisfied with the majority of the services provided. Areas for improvement had been identified and discussed with the PRG and published on their practice website. These covered the availability of seeing or speaking to someone, waiting times and awareness of the out of hour's system of obtaining access to a GP. At the time of our inspection the practice was working closely with the PRG to initiate improvements.

Management lead through learning and improvement

Are services well-led?

Good 

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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 and they were encouraged to develop themselves.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff at team meetings. The lead GP at the practice was responsible for cascading all relevant learning to staff and we could see from records held that this was being undertaken. Staff spoken with had an awareness of the incidents that had occurred in the past and told us that learning from them was a common theme at the meetings they attended.

The practice had recognised an area of improvement with their minutes of team meetings. A system was in place that enabled staff members who could not attend meetings, to have the minutes of those meetings available for them but there was no system for noting that they had been read. The practice manager was in the process of introducing minutes that were circulated amongst staff who then had to sign/initial that they had been read. This ensured that staff had been made aware of important issues such as the learning from safety incidents and complaints.

The practice held monthly lunchtime meetings where guest speakers were invited to attend to provide training for staff. Examples of learning included care and treatment in relation to pain management and ear, nose and throat conditions.