Southwell Medical Centre

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?	Outstanding
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

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Southwell Medical Centre on 25 February 2015. Overall the practice is rated as good.

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

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 good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice, including:

- The practice provided outstanding support to patients receiving end of life care and their relatives and carers.

Summary of findings

Support following bereavement was also outstanding. We saw that GP's provided contact details to patients nearing the end of their life to ensure they had access to a GP who knew them out of hours to ensure continuity of care.

- The practice had robust safeguarding procedures, particularly for children including well established strong links with other safeguarding agencies. They always attended child protection meetings in person.
- The practice had identified that students did not access GP services well. To address this, the practice manager attended fresher's week at the nearby university site to advise students how best to use the practice. The location of the university site was very isolated and the practice had identified that students could experience poor mental health as a result. They had therefore developed strong links with the mental health support team to offer help advice and early intervention.
- The practice provided caring and responsive medical care to a respite home for children and young people with physical and learning disabilities. Including GP's working late to ensure the residents had access to care and treatment when needed.

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. Robust safeguarding systems were in pace to protect children ad vulnerable adults from harm including the named GP attending every child protection meeting in person.

Lessons were learned from untoward incidents and events and were communicated within the practice 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 people safe. Processes were in place to check medicines were within their expiry date and suitable for use.

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 CCG area. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice had a system in place to undertake clinical audits but not all of these were completed cycles able to demonstrate improvements in patient outcomes. These systems should be strengthened.

Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had carried out appraisals and the personal development plans for the majority of staff, however due to illness some appraisals required updating. Staff worked with multidisciplinary teams to ensure the best outcomes for patients. For example, the practice worked with specialist nurses, physiotherapists and a range of professionals from other services to prevent people from being admitted to hospital when this was not necessary.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

A commitment towards patients and their wellbeing was embedded across the service and this was a vision shared by all practice staff. The practice provided patient centred care and had put in place several initiatives to ensure the health and wellbeing of their patients which was over and above their contractual obligations.

Summary of findings

For example, GP's provided on call contact details to patients nearing the end of their life to ensure they had access to a GP who knew them and their wishes out of hours to ensure continuity of care. We saw a significant number of letters and cards from patients' relatives thanking the practice for their exemplary care in these circumstances. The practice had a university campus nearby (but was not a university practice); the location of this site was very isolated and the practice had identified that students could experience poor mental health as a result. They had therefore developed strong links with the mental health support team to offer help advice and early intervention and attended fresher's week to encourage them to use the practice for support as well as treatment.

Data showed that patients rated the practice higher than others for several aspects of care. For example, time spent with the GP, involvement in care and being treated with dignity and respect. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Support was available for patient's carers and their families throughout their treatment and the practice identified this was an area of particular strength.

The practice provided caring and responsive medical care to a respite home for children and young people with physical and learning disabilities. Including GP's working late to ensure the residents had access to care and treatment when needed.

Comments from patients and those we received on comment cards showed that patients valued the service very highly and a number of patients used words such as 'outstanding', 'excellent' and 'exceptional' to describe the service provided at the practice. Staff at a care home for young people with physical and learning disabilities praised the practice attitude towards their residents and the level of involvement and care offered by the GP's. They told us the practice communicated well and the receptionist alerted the GP when patients arrived to ensure they did not have long to wait. A quieter room was allocated for them to wait in.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population to secure improvements to services where these were identified. The practice was situated some distance from the nearest emergency department and provided a minor injuries clinic to prevent patients having to travel excessive distances to the hospital. 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

Summary of findings

day. 77% of patients who responded to the 2014/15 GP Patient survey said they were able to see the GP of their choice at a time that was convenient. This was much higher than the CCG (61%) and National (60%) averages.

The practice had good facilities and was well equipped to treat patients and meet their needs. For example the building had level access and toilets which were accessible to people in wheelchairs, parents with push chairs and those with reduced mobility. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Practice staff had access to translation services to assist people who did not have English as their first language. Learning from complaints with staff and other stakeholders was discussed at team meetings.

Are services well-led?

Good

The practice is rated as good for well-led.

The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear and consistent leadership structure with low staff turnover and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. 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.

The practice population had a much higher percentage of older people than local and national averages. However nationally reported QOF data showed that outcomes for patients were good for conditions commonly found in older people when compared to local CCG and national averages. For example stroke (99.95 % compared to CCG and National figures of 97% and 95%) and heart failure (100% compared to CCG 100% and National 97%).

The practice provided personalised care to meet the needs of all patients including the older people in its population by using a 'usual doctor' system. This system involved one GP looking after their nominated patients. Patients were able to see any GP, but all tasks, results, secretarial work, follow ups and problems, were dealt with by the patient's 'usual doctor' to ensure continuity of care.

Regular visits were carried out to three care homes and support and advice was provided to patients and staff. A range of enhanced services, for example, in dementia and end of life care were provided. The practice was responsive to the needs of older people, and offered home visits and longer appointments when required.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Longer appointments and home visits were available when needed. All these patients had a named GP using the 'usual doctor' system and a structured annual review to check that their health and medication needs were being met. Nationally reported QOF data showed that the practice was performing above local and national averages for a range of long term conditions, for example;

- Asthma – 100% compared to CCG 98%– and National – 97% averages
- COPD– 100% compared to CCG 97% – and National – 95% averages

The practice provided a base for specialist nurse practitioners in specialities such as heart failure and diabetes. This enabled faster assessment and access to care for patients with the most complex needs.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were higher than local and national averages for all standard childhood immunisations.

Patients we spoke with told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Appointments were available at convenient times and the premises were suitable for children and babies, with a designated children's waiting area. The practice was a base for midwives, health visitors and school nurses which enabled joint working, good communication and positive outcomes for patients.

GP partners attended safeguarding case conferences in person for children and families who may be at risk of harm and robust safeguarding and protection systems were in place.

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. For example the dispensary and administration offices were open on Saturday mornings to enable patients to collect prescriptions, medicines and test results if they could not attend the practice during the working week

Appointments and repeat prescriptions could be booked in person, via telephone or online via the practice website.

The practice had made efforts to ensure that students were aware of how access GP services by attending at the nearby university campus to advise students how best to use the practice. Additionally the practice had identified that due to its isolated rural location students living on this campus could experience poor mental health such as depression, isolation and stress. As a result they had developed strong links with the mental health support team to offer help advice and early intervention.

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.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Practice records showed that 37 patients were registered with a learning

disability. Although not all patients were able to attend the practice, 13 had received a health check and a further 12 had received a medication review at the time of our inspection. Additional reviews were planned throughout the year.

The practice was responsive to the needs of vulnerable people. Patients with learning disabilities and those who may be anxious were given priority access to their appointment so they did not have to wait. A quiet room, away from the waiting area was also available for patients who may become anxious.

The practice provided caring and responsive medical care to a respite home for children and young people with physical and learning disabilities. Including GP's working late to ensure the residents had access to care and treatment when needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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).

Comments received from patients experiencing poor mental health praised the practice for the level of support and care offered. All of the 37 comment cards were positive about the approach practice staff had towards them. Several comments from patients experiencing mental ill health indicated how supportive the practice staff were.

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 practice was responsive to the needs of patients experiencing poor mental health. Priority access and longer appointments were available and the needs of students experiencing isolation and depression had been considered.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We looked at the patient survey data which was published in January 2015. The survey was sent out to 253 patients and there were 125 returned responses. This was a 49% response rate. The data demonstrated the practice performed well in the following areas:

84% of patients said they would recommend the practice to someone new to the area.

90% of respondents said they found the receptionist helpful.

77% of respondents with a preferred GP usually got to see or speak to that GP.

These results were all above the results for other practices within the CCG area.

The practice performed less well in the following areas:

58% of respondents said they usually waited for 15 minutes or less after their appointment time to be seen.

67% of respondents were satisfied with the practice opening hours

These results were below the results for other practices within the CCG area. The practice were aware of these findings and explained they provided patients with the time they needed during appointments to offer appropriate care and treatment rather than rushing them.

We considered the seven patient reviews of the practice on NHS Choices from the last year and the practice staff had posted a response to all except the most recent comment which they were aware of but had not had time to respond to. Patients were offered apologies or opportunities to contact the practice for further discussion or to raise complaints where appropriate. Several of the comments related to a period when the practice staff were waiting for a new GP to start working and the action the practice was taking to recruit was made clear in the responses to patients.

We received 37 comment cards they were all very positive about the approach, care and treatment the staff at the practice provided. 14 patients used words such as 'outstanding', 'excellent' and 'exceptional' to describe the service provided at the practice. Common themes were that staff were caring, compassionate and that patients felt they were treated with dignity and respect. Patients also commented that the GPs listened to them and the comment cards provided several examples of the GPs and nurses going the extra mile to ensure they had the diagnosis, assessment and treatment they needed to maximise their health and wellbeing. A few patients commented about how difficult it was to get through to the practice on the phone or to secure an appointment but these were in the minority of cases.

We spoke with five patients during our inspection, all of whom were positive about their experiences of the service.

Outstanding practice

• The practice provided outstanding support to patients receiving end of life care and their relatives and carers. Support following bereavement was also outstanding. We saw that GP's provided contact details to patients nearing the end of their life to ensure they had access to a GP who knew them out of hours to ensure continuity of care.

• The practice had robust safeguarding procedures, particularly for children including well established strong links with other safeguarding agencies. They always attended child protection meetings in person.

• The practice had identified that students did not access GP services well. To address this, the practice manager attended fresher's week at the nearby university site to advise students how best to use the practice. The location of the university site was very isolated and the practice had identified that students could experience poor mental health as a result. They had therefore developed strong links with the mental health support team to offer help advice and early intervention.

Summary of findings

• The practice provided caring and responsive medical care to a respite home for children and young people with physical and learning disabilities. Including GP's working late to ensure the residents had access to care and treatment when needed.

Southwell Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP, a practice manager and an inspection manager.

Background to Southwell Medical Centre

Southwell Medical Centre is a partnership between four partners operating from a single branch.

The practice has approximately 12,000 patients with an increasing number of patients registering at the practice.

The area the practice serves is one of the least deprived areas in the country and the average life expectancy for men and women in the area is in line with the national average. There is a fairly even age range of patients registered at the practice but data shows the majority of patients on the practice list are between the ages of 40 and 69, being working age or recently retired. Data shows there are a greater than average number of patients aged 10 to 19 and 65 and over.

There are four partners and three salaried GPs working at the practice, a whole time equivalent of 6.4 GPs. There are 58 GP sessions a week and 696 nursing slots available a week when the practice is fully staffed. In addition there are a further 10 emergency appointments available with the triage nurse two mornings per week. There are three female and four male GPs offering patients a choice of the gender of their GP. Southwell Medical Centre is a training practice and has two doctors in training placed with them at present.

The GPs are supported by a team of three practice nurses, four healthcare assistants a phlebotomist and four administrative and reception staff. The team are led by a practice manager and a deputy practice manager.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services.

The practice have opted out of providing out-of-hours services to their own patients and this service is provided by Central Nottinghamshire Clinical Services Limited.

Why we carried out this inspection

We inspected this service as part of our new 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

Prior to our inspection we reviewed information about the practice and asked other organisations (including the CCG,

Detailed findings

NHS England area team, HealthWatch, the overview and scrutiny committee of the local authority and the local medical committee) to share what they knew about the service.

We carried out an announced comprehensive inspection of this practice on 25 February 2015.

During our visit we spoke with a range of staff (including four GPs; two practice nurses, the dispensary manager, one healthcare assistant and four administrative and reception staff). We spoke with three patients who used the service and four members of the patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 37 comment cards where patients and members of the public shared their views and experiences of the service.

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)

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, near misses as well as comments and complaints received from patients. The practice maintained a log of all such incidents which may affect patient safety and this clearly highlighted action taken to ensure the patient was safe and to prevent the incident occurring again.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example after a bank holiday weekend staff were unable to access the telephone system. An action plan was put in place to prevent this happening again including access to an override function allowing staff control of the telephone system at all times.

The GP partners demonstrated a sound knowledge of their responsibilities in managing significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record in 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. The template for recording all significant events was held on a shared drive so all staff could access these. All staff were encouraged to record all incidents and near misses on the template to allow reflective learning to take place.

The practice held three monthly meetings called SENA (Significant Event, Near miss and Audit) meetings to discuss significant events, near misses and audits. These meetings were attended by all clinical practice staff and included administration staff if relevant. The partners produced an annual summary of all significant events to enable them to identify patterns and ensure learning was being embedded in practice.

There were records of significant events that had occurred during the last year and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example a patient presented at the practice requiring emergency medical assistance. Following their successful treatment, a debriefing meeting was held and actions agreed including having additional medicines on the resuscitation trolley and charts to record actions and debrief. There were no patterns of significant events which indicated the learning was put in to place and embedded in practice. 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.

National patient safety alerts were disseminated to practice staff via email from the practice manager. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were shared with staff and discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw evidence of this in meeting records.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults, including having dedicated leads for both child and adult safeguarding. The safeguarding leads had undertaken an appropriate level of safeguarding training provided by the CCG to ensure they fully understood their roles and responsibilities. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

We looked at training records which showed that all other staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff 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 were easily accessible.

The safeguarding leads held a three monthly safeguarding meeting with health visitors and school nursing teams as well as child and adult social care staff to ensure that any

patients who were vulnerable or at risk of harm or abuse were discussed and care, support and treatment was planned and co-ordinated effectively with the safety of the patient in mind. GPs we spoke with told us that there were also regular informal contacts with both the Health Visitors and the school nursing teams who were based at the practice.

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 GP was aware of vulnerable children and adults at the practice and records demonstrated extremely good liaison with partner agencies such as the police and social services. GPs told us they always made every attempt to attend child protection conferences in person and usually achieved this. If they were unable to attend they told us they always sent a report to the meeting. Non practice healthcare staff we spoke with commented positively on the practice GP's regular attendance at these meetings

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 children subject to child protection plans, looked after children or those living in situations of domestic violence.

There was a chaperone policy, which was visible on the waiting room noticeboard and in 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 and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators 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 policy.

Processes were in place to check weekly that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations and standard operating procedures within the dispensary.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included an audit to ensure practice was in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescriptions could be requested on repeat for a maximum of six months before triggering a medicines review. The GPs were reminded of this at five months by a task on the electronic system. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the recording of stock and the destruction of controlled drugs.

The CCG undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had a dispensary on site for patients to collect their prescription. This was staffed with two full time and two part time members of staff.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice.

Good

Are services safe?

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

Cleanliness and infection control

The practice were registered to undertake surgical procedures and also provided a minor injuries clinic to prevent patients having to travel excessive distances to the accident and emergency departments. All treatment rooms were fitted with sealed unit flooring which could be easily cleaned and decontaminated.

We observed the premises to be clean and tidy and the practice employed their own cleaning staff. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke to told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had not undertaken further training to enable them to provide advice on the practice infection control policy. This was in the process of being sourced. The lead had established links with the public health infection control matron who posted research on the internet for practices to refer to. All staff received induction training about effective hand washing, but not all staff had received recent infection control training specific to their role. Following our inspection the practice provided evidence that all staff, including the infection control lead had received additional training.

We saw evidence that the lead had carried out two infection control audits; the last one was completed in February 2015 with the previous one taking place in December 2013. Where these allowed the lead nurse to comment on aspects of infection control, there was no evidence to demonstrate an action plan had been written in response to the issues identified, though these were all minor. The staff we spoke with told us the nursing team held a weekly clinical supervision meeting where any infection control issues were discussed and actions agreed.

An infection control policy and supporting procedures were available for staff to refer to on the shared system. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The equipment used by clinical staff (such as elbow operated taps, pedal operated bins for specific types of waste and clinical waste and hand sensors for dispensers) minimised the risks of infections passing between patients and staff. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw each sharps container had the number of Public Health England printed on them in case staff needed advice following needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. All products subject to Control of Substances Hazardous to Health (CoSHH) Regulations were secured in appropriate storage.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had a service agreement with an external company to carry out regular checks in line with this policy to reduce the risk of infection to staff and patients.

The practice manager and nurses maintained a list of all staff who had been vaccinated against the flu virus and there was a record of staff's Hepatitis B status.

Equipment

Staff we spoke with told us they had 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, blood pressure measuring devices and the fridge thermometer

Staffing and recruitment

Good

Are services safe?

We looked at three staff files and these contained evidence to demonstrate that appropriate recruitment checks had been undertaken prior to employment. For example, we saw evidence of 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 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 and equipment. The practice 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.

Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We saw evidence that any risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. A GP confirmed that this system was effective in practice and emergency situation would take priority and the patient would be seen by a GP.

If children or young people were unwell they would be prioritised and seen immediately as the receptionists would send an instant message to a doctor. Both GPs and reception staff confirmed this would result in an immediate response.

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 (used to re-establish a normal heart rhythm in an emergency) and a nebuliser. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this and made changes to their emergency equipment as a result.

Emergency medicines were available in the dispensary of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis (an extreme allergic reaction) and hypoglycaemia (low blood glucose levels). A nurse was responsible for checking the contents of the emergency stock. There was an up to date policy in place in respect of emergency medicines which was updated in August 2014 and a comprehensive checklist to ensure all items were in date and in stock.

The practice did not routinely hold stocks of medicines for emergency treatment in their doctor's bags. The reason for this was that they rang each patient for a summary of their symptoms before visiting and if in their medical opinion they felt that may lead to a need for a prescribed medicine they would take this out with them. This had not been subject to a written risk assessment , but the GPs we spoke with told us they did not do very many home visits, had never had an incident and if they needed the medicine they would return to the practice.

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

Good

Are services safe?

building, mitigating actions were identified for all possible eventualities. The document contained relevant contact details for staff to refer to and each GP held a copy of this at their home address.

The practice had carried out a fire risk assessment in July 2014 that included actions required to maintain fire safety.

Records showed that staff were up to date with fire training and that they undertook regular checks on the fire alarm and emergency lighting systems. There was a designated fire marshal at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. All of the GPs told us that they discussed any new guidelines at their weekly meetings and searched for NICE guidelines on line. 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.

The GPs told us they led in specialist clinical areas such as cancer, palliative care and INR testing (International normalized ratio - a test to measure how effectively a patient's blood forms clots, used for patients on anti-coagulation therapy such as warfarin).

The practice nurses supported work with patients with long term conditions, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for example in respect of irritable bowel syndrome. Our review of the clinical meeting minutes confirmed that this happened.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. 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, which required patients to be reviewed within a week by their GP according to need.

National data showed that the practice referral rates to secondary and other community care services were much higher than other practices in the local area. All partners we spoke with were aware of this and commented that the referrals they made resulted in treatment being provided which they felt demonstrated that the referral was justified. The GP partners used national standards for the referral of patients with suspected cancer and they were performing well in respect of the percentage of patients with suspected cancer referred and seen within two weeks (64.9%) when compared with the national average (48%)

Management, monitoring and improving outcomes for people

The practice showed us the list of clinical audits undertaken since 2008. Last year the practice had undertaken five clinical audits. One of these was a completed audit cycle where the practice was able to demonstrate the changes resulting since the initial audit. This audit was concerned with identifying whether they were following best practice guidelines in respect of patients with Irritable Bowel Syndrome (IBS). NICE guidelines indicated that patients should have been tested for coeliac disease before a diagnosis of IBS was confirmed.

The initial audit identified that only 51% of patients with a written diagnosis of IBS had been tested for coeliac disease. The GPs cascaded learning to the practice team. The audit was repeated 12 months later and this time the audit identified 81% of patients with a diagnosis of IBS had received a test for coeliac disease. The completed cycle demonstrated improvements in the number of patients who could be assured that their diagnosis was correct.

Other examples included an audit of the prescribing of a high risk medication following a significant event which highlighted the patient had not been receiving the correct monitoring of their health. The result of the audit was that 79% had the correct monitoring, with 21% of patients who did not. The GPs had cascaded recommendations in line with prescribing guidelines to all clinical staff.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Practice staff told us they knew they performed very well in relation to outcomes for patients living with long term conditions such as asthma and data supported this. For example, 95% of patients with asthma had a record of their smoking status and 93% of patients with COPD (chronic obstructive pulmonary disease (lung disease) had undertaken a review of breathlessness. The practice met all the minimum standards for QOF in asthma, COPD, depression, epilepsy,

Good

Are services effective?

(for example, treatment is effective)

heart failure, hyper thyroidism, palliative care and learning disability (recording 100% achievement of targets) and was performing above the CCG and national averages for all areas.

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, as a group, they reflected on the outcomes being achieved and areas where this could be improved. It was clear from the practice presentation, comments from staff and the PPG (patient participation group) that there was a positive culture at the practice and a commitment to continuous quality improvement and positive patient outcomes.

The practice was working 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses the practice deemed mandatory such as annual basic life support, manual handling, fire safety, safeguarding and health and safety. We noted a good skill mix among the doctors. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook appraisals that identified learning needs from which action plans were documented. The Practice Manager, Deputy Practice Manager and Nurse Manager undertook all appraisals . The Deputy Practice Manager understood she needed to get a number of appraisals up to date. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, dispensing staff had been supported to attain nationally recognised qualifications and nursing staff were supported to complete additional training in management of diabetes and asthma.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. There were robust systems in place to support doctors in training and to ensure that their treatment of patients was safe and appropriate. We saw that following each session carried out by a GP registrar they would discuss all consultations with their mentor to identify learning and offer support. Clinical support and confirmation for diagnosis and advice was available to all registrars and nurses from the GP's throughout the clinics.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology and asthma or diabetes reviews. Those with extended roles, for example carrying out health reviews for patients with long term conditions, were also able to demonstrate that they had appropriate training and had gained additional qualifications to fulfil these roles.

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. Each patient had a named GP who took responsibility for reviewing letters and results in respect of them. If the GP was on leave the result would be reviewed by the duty Doctor each day. The GP who saw these documents and results was responsible for the action required. Additionally, all Out-Of-Hours forms for absent GPs were also screened by Deputy Practice Manager or Practice Manager before review by the Duty GP. 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.

The practice was commissioned for the new enhanced service to prevent unplanned admission to hospital and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary team meetings using a system called Profiling Risk, Integrated Care, Self-Management (PRISM) to discuss the needs of complex patients, for example those nearing the end of their life. These meetings were attended by social workers, OT (Occupational Therapist), physiotherapist and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well.

The practice provided GP services to five care homes including two for young people with physical and learning disabilities. GP's at the practice provided clinical support and advice to Advanced Nurse Practitioners at all the homes and two care homes had named GPs with support for a larger, 71 bed, home shared across all GPs at the practice. Staff at a care home for young people with physical and learning disabilities praised the practice attitude towards their residents. They told us the practice communicated well and the receptionist alerted the GP when patients arrived to ensure they did not have long to wait. A quieter room was allocated for them to wait in.

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. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff told us this system was easy to use.

The practice gave patients a printed copy of a summary record for the patient to take with them to A&E to ensure the emergency department staff had immediate access to key information about the patient's health and medical history.

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 said it was easy to 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

We found that 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.

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) and had a section stating the patient's preferences for treatment and decisions. We saw an example of a referral to social services by the practice on behalf of a vulnerable patient for a best interest decision to be made regarding the safety of their current place of care.

All clinical staff demonstrated a clear understanding of Gillick competencies. (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).

There was a practice policy for documenting consent for specific interventions. We saw this policy had been updated in February 2105 and included an example of a minor surgery consent form. A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or 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. GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. These were repeated every five years. If a patient did not attend, three reminders were sent at three month intervals. We saw that 1646 (36.5%) of eligible patients had accepted the invitation for this health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

Good

Are services effective?

(for example, treatment is effective)

offering additional help. For example, the practice kept a register of all patients with a dementia and all 126 were offered an annual physical health check. Practice records showed 62 (49%) had received a check up in the last 12 months. Practice records showed that 37 patients were registered with a learning disability. Although not all patients were able to attend the practice, 13 had received a health check and a further 12 had received a medication review at the time of our inspection. Additional reviews were planned throughout the year.

The practice's performance for cervical smear uptake was 82.6% in the year 2013 - 2014, which was better than the CCG (78.4%) and national (74.3%) rates. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening which was supported by the practice policy. Performance for mammography and bowel cancer screening in the area were all above average for the CCG and the national average at 79.9% and 72.9% respectively. A similar mechanism of following up patients who did not attend was also used for these screening programmes.

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 similar to other practices in the CCG area, and the percentage of patients who had received the flu vaccination (79.58%) was much better than the England average of 73.24%.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the patient survey data which was published in January 2015. The survey was sent out to 253 patients and there were 125 returned responses. This was a 49% response rate. The practice performed well when compared with others in the local area in respect of how patients reported they were treated. For example 87% of respondents stated that their GP was good at giving them enough time (94% in respect of nurses), 82% said the GP was good at treating them with care and concern (96% in respect of nurses) and 91% said the GP was good at listening to them (93% in respect of nurses).

A commitment towards patients and their wellbeing was embedded across the service and this was a vision shared by all practice staff. The practice provided patient centred care and had put in place several initiatives to ensure the health and wellbeing of their patients which was over and above their contractual obligations.

For example, GP's provided on call contact details to patients nearing the end of their life to ensure they had access to a GP who knew them and their wishes out of hours to ensure continuity of care. We saw a significant number of letters and cards from patients' relatives thanking the practice for their exemplary care in these circumstances.

The practice had a university campus nearby (but was not a university practice); the location of this site was very isolated and the practice had identified that students could experience poor mental health as a result. They had therefore developed strong links with the mental health support team to offer help advice and early intervention and attended fresher's week to encourage them to use the practice for support as well as treatment.

Comments from patients and those we received on comment cards showed that patients valued the service very highly and a number of patients used words such as 'outstanding', 'excellent' and 'exceptional' to describe the service provided at the practice. Patients commented they were treated with care, compassion, dignity and respect. This was confirmed by our observation throughout the inspection. No concerns were raised by anyone about the way they were treated.

Staff at a care home for young people with physical and learning disabilities praised the practice attitude towards their residents. They told us the practice communicated well and the receptionist alerted the GP when patients arrived to ensure they did not have long to wait. A quieter room was allocated for them to wait in.

We saw that all staff had completed equality and diversity training which helped them understand the needs of all patient groups. Five patients that we spoke with on the day of our inspection told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice staff had access to an interview room where patients could discuss any issues confidentially without the risk of being overheard by others. The staff we spoke with told us this was used regularly. This room was also used for people experiencing mental health crisis or for patients with a learning disability to maintain their dignity and provide a more comfortable place for them to wait.

Staff 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. There were also portable screens at the practice for use if patients became unwell in public areas to maintain their privacy and dignity. These were purchased following a significant event. We noted that consultation and 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 telephones were located away from the reception desk which helped keep patient information private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour, although reception staff told us they had not had to refer to this.

Care planning and involvement in decisions about care and treatment

The practice performed well in respect of how well informed and involved in care and treatment respondents

Are services caring?

felt. For example 85% of respondents said their GP was good at explaining tests and treatment (91% in respect of nurses) and the same percentage said the GP was good at involving them in decisions about their care or treatment (86% in respect of nurses).

Each patient identified by the Profiling Risk, Integrated Care, Self-Management (PRISM) risk profile had a care plan in place and GPs wrote the initial care plans for each patient. We looked at an example of a care plan and this contained comprehensive information about the needs of the patient, their wishes and preferences and how they would like their care managed in an emergency.

Patients we spoke with on the day of our inspection 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.

The 37 comment cards we received all indicated practice staff listened to them, explained any tests or treatment and the reasons this was deemed necessary and involved them in decisions. There were no negative comments about this area and this demonstrated the practice consistently approached patients as partners in their care and treatment and worked with them when deciding on the appropriate care and treatment to maintain their health. Several patients gave us examples of the GPs and nursing staff going the extra mile to ensure they were assessed, diagnosed and treated appropriately.

We saw that older patients, those with long term conditions and patients with learning disabilities were supported to make decisions through the use of care plans and were fully involved in the design and content of them. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Patient/carer support to cope emotionally with care and treatment

Patient survey data indicated that patients felt emotionally well supported by practice staff. For example 82% said the GP was good at treating them with care and concern (96% in respect of nurses).

All of the 37 comment cards were positive about the approach practice staff had towards them. Several comments from patients experiencing mental ill health indicated how supportive the practice staff were.

Notices in the patient waiting room, on the digital display screen 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 also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw that GP's gave contact details to the families and carers of patients who were nearing the end of their life to ensure they had access to a GP who knew them and their wishes out of hours to ensure continuity of care. Additionally GPs liaised with out-of-hours services to inform of them of patients receiving end of life care and informed families and carers when the GP would be covering out-of-hours shifts or working at the walk in centre to enable them to access care from their own GP.

Staff told us that if families had experienced a bereavement, their GP would contact them. This call would be followed up a few weeks later to offer support and advice if required. We saw records of two examples of these support calls. In one example the bereaved patient had received support and welfare calls for over two years. We spoke with one patient who had received this type of support who told us they had found it incredibly helpful and caring.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, a PPG patient survey identified concerns with access to appointments and difficulty in getting through on the telephone. The practice had instigated nurse triage and online booking. Additionally the practice invited tenders for a new telephone system which the PPG members were involved in reviewing. A follow up survey showed only a slight improvement with patient satisfaction although this may reflect the relatively short time the new system was operational.

The practice was working towards the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. The practice held End of life meetings quarterly, clinical team meetings monthly and PRISM meetings monthly. Each meeting included discussions regarding patients with additional support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients with long term conditions or those with learning disability were given longer appointments with nurses of up to 45 minutes if required. Additionally, patients with learning disabilities and those who may be anxious were given priority access to their appointment on arrival at the practice. A quiet room, away from the waiting area was available for patients who may become anxious. Staff at a care home for young people with physical and learning disabilities praised the practice attitude towards their residents.

The majority of patients registered at the practice spoke English as their first language. The practice had access to online and telephone translation services but given the practice patient demographic had very little need to access this.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training. During our inspection we saw that all patients and visitors were treated with dignity and respect.

The premises and services had been adapted to meet the needs of patient with reduced mobility. There was level access throughout the building with wider doors to allow wheelchair access. All clinical areas were situated on the ground floor to enable patient's ease of access. The practice had adapted toilet facilities, including handrails and emergency pull cords. The practice had baby changing facilities available.

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. There was a lift available giving access to the first floor rooms.

Access to the service

We looked at the patient survey data which was published in January 2015. The survey was sent out to 253 patients and there were 125 returned responses. This was a 49% response rate.

Patients reported a mixed experience of making appointments in the patient survey, but 90% of respondents said they could get an appointment to see or speak to someone the last time they tried and 92% said the time they got was convenient to them. However, in spite of this only 67% described their experience of making an appointment as good and only 68% found it easy to get through to the practice on the phone. The practice had instigated nurse triage system and purchased a new telephone handling service to address these issues. At the time of our inspection these steps had had a small but positive effective on patient satisfaction.

Appointments were available from 8am to 6pm on weekdays, with the dispensary and administration offices open from 8am to 10:30am on Saturdays to enable patients to collect prescriptions, medicines and test results if they

Are services responsive to people's needs?

(for example, to feedback?)

could not attend the practice during the working week. Once all GP appointments are filled the nurse triaged all patients and had the potential to book in emergency appointments with the GP. Appointments could be booked in person, via telephone or online via the practice website.

Comprehensive information was available to patients about appointments on the practice website and in the practice information folder for patients. This included how to arrange urgent appointments and home visits. 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.

Longer appointments were available for patients who needed them and the surgery information folder indicated some of the circumstances where this may be necessary. The practice staff tried to minimise distress to patients with a learning disability by ensuring they went into their appointment as soon as possible and by enabling them to wait in a quiet room rather than the waiting area. This was confirmed by staff at care homes we spoke with and was appreciated and valued.

The practice offered 'walk in' appointments, which did not require advance booking or waiting for children who may be seriously ill. A section of the waiting area was designated for children and families with toys and books to allay boredom. Breastfeeding was supported by the practice. Staff told us mothers could use a one of two rooms if they required privacy. The practice hosted the local school nurse and health visitor and the PPG had held public health education meetings at local schools.

Home visits were made to five local care homes and each care home had a named GP. The GPs demonstrated a high degree of flexibility in their approach to working with patients receiving respite care in a local care home for children with physical and learning disabilities. They recognised that they were usually admitted on a Friday afternoon and would be flexible in ensuring they could be fitted in for urgent appointments if needed. Children receiving respite care were registered as temporary patients.

Patients were generally satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Patients we spoke with told us they were able to get same day appointments if they telephoned the practice in the morning. They told us this may not be with the GP of their choice but all were satisfied with the service offered.

The practice had a high proportion of patients over 65 and they were proactive in ensuring that they were responsive to the needs of older patients. For example a GP told us about reception staff changing appointments or arranging these around the bus times for older patients who used public transport.

The practice had identified that students did not access GP services well. To address this the practice manager attended fresher's week at the nearby college to advise students how best to use the practice.

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.

We saw that information was available to help patients understand the complaints system, a leaflet and a poster was available outlining the complaints procedure. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at nine complaints received in the last 12 months and found that they were handled in a timely way and in line with the practice complaints policy. All nine complaints showed evidence of thorough investigation involving several members of staff and appeared to have been resolved to the complainant's satisfaction.

We saw that where lessons could be learnt from complaints these were shared with staff and changes were made to policies and procedure. For example, one complaint related to a delay in a letter being sent to the family of a patient as the GP was on holiday. Following investigation an apology was given to the family and procedures for sharing information prior to staff leave were updated.

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 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. These values were embedded in the work of the practice and their support to patients.

The practice had a strong vision and values which was embedded in all aspects of the practice. All staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. The values were; excellent care, patient safety, working together

To ensure the vision worked in practice, all patients were allocated a "usual doctor" who looked after their nominated patients. This ensured continuity of care and allowed better integration of care between the practice and allied health and social care professionals such as the PRISM and palliative care teams. We found that this led to personal care and treatment for patients and improved access and satisfaction. For example, the parent of a patient with learning disabilities needed to contact their GP for urgent information. Due to the nature of the 'usual doctor' system they told us they were able to contact the right GP and get the assistance required.

Governance arrangements

There was a strong and clear leadership structure and the partners held fortnightly meetings with the practice manager who took a lead on the overall leadership and governance of the practice day to day.

Named members of staff had lead roles. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

There was a strong commitment to patients which was evident in interviews with all practice staff and this was confirmed by patient feedback.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures. All eight policies and procedures we looked at had been reviewed annually 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 or better than national standards. We saw that QOF data was regularly discussed at fortnightly clinical team meetings and action plans were produced to maintain or improve outcomes.

Risks were identified, assessed and actions were in place to mitigate against these to protect patients, staff and visitors against the risk of harm. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

There was an open and transparent culture at the practice and a commitment to learn and improve. We saw from minutes that team meetings were held regularly, at least monthly. All staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise any issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for health and safety, infection control and recruitment which were in place to support staff. We were shown the electronic staff handbook that 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.

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

The practice had gathered feedback from patients through comments cards, patient surveys and online comments and complaints received. We looked at the results of a patient satisfaction surveys carried out by the PPG in 2014. These showed that all patients who responded were happy with the care and treatment they received, although access to appointments was an ongoing concern.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. The PPG had carried out annual patient satisfaction surveys and met regularly. The practice

Are services well-led?

Good

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

manager showed us the analysis of the last patient survey, which was designed, carried out and analysed by PPG members. We saw notes of a meeting, attended by the PPG, practice manager and GP's where the findings of the survey were discussed and action points agreed.

The PPG worked closely with the practice and had carried out fund raising to purchase equipment to benefit patients and staff, for example adjustable examination couches and dermatascopes to help speed up diagnosis of skin conditions including melanoma.

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 colleagues and management and that they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us they were able to ask for additional training for their role. We saw that staff had asked for and been authorised to attend training to administer vaccines, carry out health checks and understand long term conditions. This improved accessibility and outcomes for patients. 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

There were systems in place to enable the GPs to benefit from peer support and discussion. Educational afternoons were held once a month where guest speakers were invited based on identified learning needs for the practice. For example a specialist's stroke physician gave an update on anti-coagulation use which led to improved management of patient's health and wellbeing.

Clinical staff told us that the partners supported them to continue their 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 felt being an accredited training practice had been a very positive development for staff and patients. Staff told us they were not only supported to attain training required to maintain their professional registrations but also additional skills such as prescribing or management of long term conditions.

The practice was an accredited GP training practice and we saw evidence of regular mentoring, training and feedback to trainees.

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. We saw that an action plan was developed and implemented for each significant event investigated.