Moulsham Lodge Surgery

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 Moulsham Lodge Surgery on 05 August 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

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 but their assessments would benefit from further development.
- 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 they were able 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.

Summary of findings

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

Importantly the provider should

- Ensure records are maintained for all meetings held.
- Ensure cleaning records are maintained and reflective of the cleaning undertaken.
- Ensure risk assessments are reflective of current risk. Where issues have been identified the provider should record who has been assigned actions, timescales for completion and when the task had been completed.
- Take steps to provide all staff with fire safety and evacuation training

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement although these were not routinely documented. Staff had been trained and knew how to recognise and report safeguarding concerns. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed although not always documented including the assignment of actions and outcome. The practice was visibly clean and tidy although we found cleaning records were not consistently maintained and reflective of cleaning undertaken. There were enough staff to keep patients safe but not all had been trained in fire safety and evacuation procedures.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it when conducting clinical audits to improve patient outcomes. Patients benefitted from the GP's having specialist interests enabling them access to specialist clinics and advice at the surgery in areas such as gynaecology, dermatology and ears nose and throat. Patient 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 supervision and personal development plans for staff and staff appraisals had been scheduled. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice similar to or above the Clinical Commissioning Group and national averages for the care they received. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. The practice used

Summary of findings

both language translation services and a British sign language translator to provide a personalised service in order to best meet their patient needs. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. National data showed the practice performed below the CCG average in some areas such as patients' experience of making a booking and their ability to get through to the surgery on the phone. This was known by the practice who were working closely with their Patient Participation Group to increase the accessibility of the service. However, patients told us they could make on the day appointments 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We found learning from complaints was shared with staff and other stakeholders but not always documented.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a defined leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held governance meetings although these were irregular and not always recorded. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and valued by the practice that held regular informal and formal meetings. Staff received inductions, supervision and attended staff meetings.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, identifying and co-ordinating care within a multidisciplinary team and offered home visits.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Patients also benefitted from a GP with specialist interest in gynaecology. Health promotional information was available within the waiting areas specifically for women regarding pre and postnatal care and sexual health advice services for young people.

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

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening services that reflects the needs for this age group. Patients benefitted from GPs with specialist interests enabling patients access to specialist clinics and advice in areas such as ears nose and throat, dermatology, gynaecology, gastroenterology and cardiology.

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 homeless people and those with a learning disability. Although, the practice did not conduct annual health checks for people with a learning disability.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. It had a broad range of literature available to assist patients with advance care planning for patients. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results from 2015. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received.

We reviewed the findings of the National GP Patient Survey 2015 for which there were 117 responses from the 301 questionnaires distributed to patients, a response rate of 39% of those people contacted. The practice performed above the national and Clinical Commissioning Group averages with 93% of respondents saying the last GP they spoke to was good at listening to them. 85% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. 69%of respondents said they usually waited 15 minutes or less after their appointment time to be seen. The practice performed below the Clinical Commissioning Group average and national averages for; respondents describing their experience of making an appointment as good, 64% of respondents were satisfied with the surgery opening hours, and 55% of respondents with a preferred GP said they usually got to see or speak to that GP.

We reviewed patient comments on the NHS choices website. There were six comments registered on the NHS choices site since July 2014 and the ratings ranged from a single star to five stars (top rating). Overall the comments were positive regarding the service patients received.

We received seven completed 'Tell us about your care' comment cards. These were positive about the service patients received from the clinical and administrative team. Patients commented on the caring nature of staff and the ease with which the GP accommodated their requests for appointments and home visits. They had confidence in the professionalism and commitment of the staff to meet their health and welfare needs.

During our inspection we spoke with eight patients including two members of the Patient Participation Group. They all told us that staff were polite and helpful. The patients had been with the practice for a number of years and respected and valued the service they received from the nurses and GPs. They told us that the GPs were kind, personable and consistently showed them patience and support.

Areas for improvement

Action the service SHOULD take to improve

- Ensure records are maintained for all meetings held.
- Ensure cleaning records are maintained and reflective of the cleaning undertaken.
- Ensure risk assessments are reflective of current risk. Where issues have been identified the provider should record who has been assigned actions, timescales for completion and when the task had been completed.
- Take steps to provide all staff with fire safety and evacuation training

Moulsham Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Moulsham Lodge Surgery

Moulsham Lodge Surgery has a patient population of 7100. The practice is managed by a GP partnership of three GPs who hold joint financial and managerial responsibility for the practice. The practice team comprises three GP partners two male GPs and a female GP, a salaried female GP, a prescribing nurse, practice nurses and healthcare assistants. They are supported by an administrative team consisting of reception staff, IT support and analytics, medical secretary overseen by the practice manager.

The practice holds a General Medical Services contract with NHS England who commissions the services.

The practice phone lines are open from 8am to 6.30pm Monday to Friday. The phone lines are closed between 12.30pm and 1.30pm when patients are directed to the practice's on call doctor. All appointments are pre-booked and these can be made on line, by phone or in person. Routine appointments may be booked up to four weeks in advance; alternatively patients can telephone at 8am to request an on-the-day appointment. Urgent appointments for patients are available on the day. Patients will be seen by which ever GP or nurse practitioner is available or alternatively patients may be offered a telephone triage with a GP or nurse practitioner to discuss their concern.

The practice maintains a comprehensive website that can be translated into a number of languages. It provides a range of information relating to their services including details of the appointment system, staff, clinics provided, practice news and the practice contact details.

The practice patient profile is similar to the national profile but with significantly lower levels of economic deprivation.

The practice has opted out of providing out-of-hours services to their own patients. Patients are advised to call 111 when they require medical assistance that is not an emergency. NHS 111 is available 24 hours a day, 365 days a year.

Why we carried out this inspection

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

Comprehensive inspections are conducted 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.

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)

Before visiting, we reviewed a range of information that we hold about the practice. We asked the practice to provide details of other organisations to share what they knew. We carried out an announced visit on 05 August 2015. During our visit we spoke with a range of staff, GP, practice manager and receptionists and spoke with patients who used the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, on receipt of a Medicines and Health products Regulatory Agency (MHRA) alert a task was sent to the clinicians to action the information. A search was then conducted on the patient record system to identify those patients who may be adversely affected. Where patients were identified the patients named GP would review their care. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these 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. We reviewed records of two significant events that had occurred during the last year. Significant events were a standing item on the practice meeting agenda and we found evidence that the practice had learnt from these and that the findings were shared with relevant staff. 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. For example, the practice had found the wrong medication had been prescribed to a patient. This was followed up with the prescriber, and all staff were reminded of the need to check medication prior to issuing the prescription.

National patient safety alerts were disseminated by the IT audit administrator to practice staff. 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 discussed individually and during clinical meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all 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 displayed to assist staff.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead GP was and who to speak with in the practice if they had a safeguarding concern.

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. We found staff worked effectively with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify

whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 who had child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and liaised well with partner agencies such as the police and social services. Whilst often unavailable to attend case conferences with their partner agencies (social services, schools and police) they would contribute and also enter the outcome of such discussions on the patient record.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had reviewed their annual prescribing review conducted by the Mid Essex Clinical Commissioning Group (CCG) for 2014-2015. The practice was below the CCG average for prescribing. The practice had a medicine management review programme in place whereby they worked closely with the CCG medicine management team. The practice considered all reports and reviewed patient records in response to recommendations from the CCG pharmacist. The practice also attended a locality prescribing meeting to review their prescribing patterns. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice and CCG.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Patients on warfarin benefitted from monitoring provided at the practice, therefore no longer requiring them to attend the hospital. Although some patients still chose to do so. Appropriate action was taken based on the results.

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 destruction of controlled drugs. The practice held control drugs meetings to discuss the safe and effective management of controlled drugs. We reviewed the last meeting minutes from January 2015. The meeting had been attended by the Control Drugs Officer (NHS England) and the Controlled Drug Liaison Officer (Essex Police). Their discussions related to best practice, the management of patient data, disclosure of information, the overuse of medicines and potential risks to patient safety.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate two day training and update training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in their role, as well as updates in the specific clinical areas of expertise for which they prescribed.

Good

Are services safe?

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Cleaning records were maintained but these were incomplete and did not always reflect daily cleaning conducted or enhanced cleaning conducted prior to surgical interventions. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy dated May 2013, which had been reviewed in January 2015. Supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, 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 practice had a lead GP and nurse for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and cascaded learning to staff. We saw evidence that the lead nurse had conducted an assessment of the practice's infection control measures. The document was undated, but the 2015 template had been used. In addition the practice nurse conducted monthly infection control checks. Where actions had been identified, it was unclear who had been assigned them and when they had been completed.

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.

The practice had conducted a legionella risk assessment in November 2013 for the management, testing and investigation of legionella (a bacterium 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.

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 which was July 2014 and scheduled for retesting in July 2017. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, ear irrigator, mercurial sphygmomanometer, digital blood pressure measuring devices and the vaccination fridge had been conducted in July 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff. The three staff records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 met 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and had conducted an assessment in September 2013. Where actions had been identified the practice manager was able to show us that they had been addressed. For example, the introduction of fire drill testing. However, it was not evident who had been assigned the actions and when they had been completed.

Good

Are services safe?

The practice did not maintain an organisational risk log but regularly spoke, as a staff team regarding associated risks to the practice. For example, staff told us and we saw meeting minutes of discussions held between the partners, practice manager, wider practice team, NHS England, CCG and PPG relating to the maintenance and later closure of their Galleywood branch surgery.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support with the exception of recent appointees who had been scheduled on the next available dates. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in June 2015 that included actions required to maintain fire safety. Staff had not undertaken fire training, but knew what to do in an emergency. We found fire safety evacuation plans were displayed in all rooms and the practice conducted regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE).

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They were individually informed and relevant guidance and new learning was shared during their four to six weekly clinical meetings. We saw minutes of clinical meetings which showed guidance was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they, and the nurses led, in specialist clinical areas such as diabetes, dermatology, cardiology, ears nose and throat, and mental health. 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 review and discuss new best practice guidelines. For example, the clinical nurse lead for diabetes worked closely with the lead GP to ensure the safe and effective monitoring and management of patient conditions. They followed up on patients who failed to attended or attended infrequently for reviews.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management.

The practice showed us five clinical audits that had been undertaken in the last 18 months. All were completed audits with two audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. For example, the most recent clinical audit addressed inadequate cytology. It showed that their in-house inadequate rate had declined within the year and was marginally above the national average. Despite the practice showing an improving trend they had decided to continue to monitor closely. All staff had received update training in performing cervical cytology smears. The practice had also conducted an audit for year 2013-2014 to monitor the safe and effective maintenance of Warfarin patients, by maintaining them within an acceptable clinical range. Their results showed the practice was above the National Institute for Health and Care Excellence (NICE) recommended levels of 65%. This information was shared with the partners and wider clinical team including the practice nurses and healthcare assistants who conduct the tests. In 2014-2015 the audit was revisited and again the practice found they had a higher level of success at maintaining patients within their clinical ranges and had exceeded their target range of 70%, demonstrating an improvement in their clinical performance.

The GPs told us clinical audits may be linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP

Good

Are services effective?

(for example, treatment is effective)

practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing and monitoring of warfarin. This demonstrated that the practice performed better than the nationally recommended standard for monitoring and treating patients who were prescribed warfarin (a medicine used to thin blood and help minimise risks of blood clots and strokes). The practice intended to re-audit the data within nine months.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 97% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- The dementia diagnosis rate was above the national average

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. Staff spoke positively about the culture in the practice around close working with the wider clinical team joint working and actively seeking advice and guidance.

The practice's prescribing rates were also better than the CCG and national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw the practice was proactive in educating patients on the importance of attending their medication reviews especially patients who were receiving their care through hospitals.

The practice had made use of multidisciplinary meetings for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. The practice also reviewed their GPs individual prescribing patterns to identify and address preferences in prescribing that may be contrary to guidance.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff such as those recently employed were up to date with attending courses such as annual basic life support, this had been scheduled. We noted a good skill mix among the doctors with them each having specialist interests (GPwSI). This is when a GP supplements their role as a generalist by providing an additional service whilst still working in the community. The GP's specialisms included gynaecology, dermatology and ears nose and throat conditions.

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).

Staff told us they spoke daily with the practice management team and had appraisal meetings scheduled. Our interviews with staff confirmed that the practice offered training and funding for relevant courses. For example all administrative staff had access to a range of training opportunities via eLearning. However, they were not afforded protected time to undertake it. The clinical team were up to date with training courses and any learning from courses attended were disseminated to the wider clinical team both formally through meetings and informally through team and individual discussions.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, training in women's health, travel health updates. Those with extended roles such as seeing patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease, diabetes and plastic surgery care were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice manager told us of how they had managed poor performance and staff conduct issues and demonstrated that appropriate action had been taken.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues from communications. Out-of-hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. However, the clinicians also had the facility to oversee other clinician's results and a GP was appointed lead, to ensure these were actioned in a timely appropriate manner. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively low at 11.91% compared to the national average of 14.4%. The practice was commissioned for the unplanned admissions enhanced service 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). The practice told us they experienced difficulties receiving timely information from the hospitals and often were reliant on the patients informing them of their admission. On doing so, the practice actively chased the appropriate service for discharge information.

The practice had reported difficulties and delays in their external referral management system as referrals were triaged prior to being referred on. They had recognised this and introduced systems to identify delays in the patient receiving care. They took the lead in following up on these to mitigate avoidable delays.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. These were attended by the community matron, district nursing team, social care, and GPs and practice nurses from Moulsham Lodge Surgery. However the frequency of them was often determined by the availability of other specialist parties to attend or contribute to the discussions despite being scheduled a year in advance. We reviewed the last three meeting minutes from December 2014, February 2015 and July 2015. These were well documented with patients individual care needs reviewed and actions raised and assigned to individuals. Staff felt this system worked well.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the out-of-hours services.

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. 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. For some specific scenarios where capacity to make decisions was an issue for a patient with learning disabilities.

The practice told us how they supported patients to make their own decisions and how these were documented in the patient notes. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the

Good

Are services effective?

(for example, treatment is effective)

Gillick competency test. (These are used to help assess whether a child under the age of 16 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. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for more complex surgical procedures.

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

Health promotion and prevention

It was practice policy to offer a health check 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening where appropriate and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks conducted by the practice nursing team including healthcare assistants. The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice was aware that approximately 20% of their patient population were smokers over the age of 16. They actively offered nurse-led smoking cessation clinics to these patients. The practice told us; at the time of our inspection they had a 94% success rate for the patients stopping smoking for four weeks. A patient told us how helpful the staff had been in assisting them to stop smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese, who were offered weight management advice.

The practice's performance for the cervical screening programme was 91.22%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend.

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 was similar to be expected for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 66.4%, and at risk groups 44.17%. These were slightly below national average of 73.24% for over 65 year olds and 52.29% for the at risk groups.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 85.4% to 97.8% and five year olds from 94.3% to 99.1%. These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the National GP Patient Survey 2015. The evidence from this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the National GP Patient survey showed the practice was performing similar to the Clinical Commissioning Group (CCG) and national averages and in some areas above. For example:

- 93% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 82% of respondents to the National GP Patient Survey 2015 said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

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. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. All staff were required to sign a confidentiality statement confirming they understood the policy and would adhere to the principles. In addition staff were required to, and had undertaken eLearning training on confidentiality and its practical application.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

The practice operated a zero tolerance for abusive behaviour this was outlined in their practice leaflet and on their website including their right to remove patients from their register. The leaflet advises patient that they also operate CCTV in their premises.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey 2015 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:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that the practice used two translation services. These were available for patients who did not have English as a first language or were deaf. The practice had recognised a need within their patient groups for a more personalised signing facility and used the services of a British sign language interpreter. We saw notices in the reception areas informing patents this service was available.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 85% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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 also a carer and linked them with the patient they cared for where appropriate to inform the coordination of care and services. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP visited the family and sent a card. In addition, some GP's offered a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had 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. For example, the practice had recently closed their Galleywood branch surgery. Prior to doing so they had identified those patients deemed most vulnerable such as those with learning disabilities, and those with long term conditions to invite them to remain with Moulsham Lodge Surgery. This was to provide them with reassurance and continuity of care. In addition the practice also considered representations from patients who wished to remain registered with the practice. These were individually reviewed, considering both clinical and personal circumstances of patients such as the patient's ability to access alternative services due to a reliance on public transportation.

At all times during the closure of their branch surgery the practice was in regular contact with NHS England Area Team and Clinical Commissioning Group (CCG) to manage the transition of care for patients. We spoke with the CCG who told us the practice was committed and had worked extensively with them to ensuring patient needs remained central to any discussions and would be met.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from staff, patients and the patient participation group (PPG). For example, we saw that the practice had arranged their patient information and leaflets into topic areas within their main waiting areas to assist patients. There was designated information for carers, palliative care and long term conditions such as diabetes management, young people sexual health. We also found the practice nurses did not hold specific clinics on a designated day but enabled patients to attend when available and convenient to them, for their health reviews or vaccinations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. The practice clinical team spoke a range of languages, some French, Pakistani, Urdu, Punjabi and Hindi and had two hearing loops, including one of which was portable. Staff knew how to use the hearing loop system but it was not clearly advertised.

Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The staff also told us they would seek advice from a clinician if they had concerns.

The premises were purpose built in 1960 and had since had a number of adaptations including a large two story extension in 2004 to meet the growing needs of the practice. The majority of the clinical rooms were located on the ground floor with a single consultation room situated on the first floor accessible via stairs. Whilst the hallways appeared narrow they were accessible to those patients with limited mobility. The practice told us that where patients had such needs these were flagged on their patient record and taken into account when delivering consultations.

Patients who may struggle to attend the practice may request the Moulsham Lodge Surgery and Tile Kiln Community Care Group to assist them with transport. This service was available to assist patients attend medical appointments but required a minimum of 24 hour's notice.

Staff told us that they had patients with "no fixed abode" who were registered so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice encouraged staff to undertake equality and diversity training through eLearning. We checked three staff training files and found two of the three members of staff had completed the training. However, dignity and diversity issues were regularly discussed with the team informally and during meetings.

Access to the service

The practice phone lines were open from 8am to 6.30pm Monday to Friday. The phone lines were closed between 12.30 and 1.30pm when patients were directed to the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice's on call doctor. All appointments were pre-booked and these could be made on line, by phone or in person. Routine appointments may be booked up to four weeks in advance; alternatively patients may telephone at 8am to request an on-the-day appointment. Urgent appointments for patients were available on the day. Patients would be seen by whichever GP or nurse practitioners were available or alternatively patients may be offered a telephone triage with a GP or nurse practitioner to discuss the concern. Home visits could be requested and patients were asked to contact the practice between 8.30am and 10.30am, where possible. Appointments may be confirmed by text and reminders sent.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care home and to patients when requested

The GP National Patient Survey 2015 information we reviewed showed patients had reported difficulties accessing appointments. For example:

- 64% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 59% described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 69% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 58% said they could get through easily to the surgery by phone compared to the CCG average of 65% and national average of 73%.

This was acknowledged by the practice and they had been working closely with the Patient Participation Group (PPG) to address access for patients. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Despite advertising on line appointments the practice had found that few patients used the service. They believed if the service was fully utilised this may reduce demands and frustrations by patients unable to get through on the phones to make appointments. However, the practice accepted and intended to revise their clinical capacity once their patient numbers had settled after the recent closure of their branch surgery.

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. The practice leaflet politely encouraged patients to tell staff when they got it wrong and share thoughts on how to improve the service. We found the practice complaints leaflet to be clear, explaining how to make the complaint and what they do and who they report to if they are dissatisfied with the outcome of the investigation. The practice had a complaints form and a third parties consent form for the patient to complete with another person if they were complaining on their behalf and/or the complaint related to a patient's medical care.

Patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, they all had confidence that if they had a concern then they would speak to a member of staff who would act appropriately and try to resolve it in a timely manner. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found these had been handled satisfactory, dealt with in a timely way with openness and transparency. However, there was an absence of detail regarding the investigation and how learning had been disseminated within the practice to mitigate the risk of a reoccurrence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints annually and we saw that 16 complaints had been received by the practice and an additional six comments on the website, over the last year. We looked at the report for the last review; there were no common themes to complaints received.

We found that the practice had responded appropriately to the comments registered by practice patients on the NHS choices website, a forum for patients to provide feedback on the practice. The practice manager told us of how the practice considered it important to answer concerns registered in the public domain, providing reassurance and accountability to their patients.

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, and their mission statement was "to provide high quality, easily accessible care in a family orientated environment, by a team of dedicated, well trained professional staff." We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

The practice had faced a number of challenges, primarily relating to the closure of their branch surgery at Galleywood on Friday 31 July 2015. They worked with NHS England, the Clinical Commissioning Group (CCG) and their Patient Participation Group (PPG) to manage the transition of the service and registering of patients at neighbouring practices. We spoke with one GP partner who told us they would be reviewing the service (patient numbers, staffing, clinical interventions, suitability of premises to accommodate growth, etc) within the next six months to a year to inform the development of their business strategy.

Governance arrangements

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.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP and nurse responsible for infection control and a GP lead for safeguarding children and vulnerable adults. 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.

The GP partners and practice manager took an active role, overseeing systems in place to monitor the quality of the service and ensuring they were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed with the partners and staff to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG and discussed issues with their PPG quarterly.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and remedial actions had been taken. However, these were not always recorded and/or revised to show the risk had been mitigated. For example, the health and safety assessment had not been revised since 2013 in response to the actions being resolved.

Leadership, openness and transparency

The GP partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Whilst the partners and practice team spoke daily, formal team meetings were more ad hoc and not always formalised. This the practice acknowledged as an area for development. However, staff told us that they valued the open culture within the practice and this provided them with opportunities to raise any issues, they had confident in doing so they would be fully supported. For example, we saw, following feedback from a member of staff, the practice had revised their induction procedures and spoke with staff regarding their expectations of them.

The practice encouraged feedback from their patients and were open with their PPG regarding the challenges they faces relating to the business. We reviewed the PPG meeting minutes and saw the discussion ranged from contractual issues, business plans relating to refurbishment, proposed plans to enhance patient services such as the introduction of online booking of appointments and repeat prescriptions to the provision of out of hour's services and walk in health facilities.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the Patient Participation Group (PPG), national and local patient surveys and complaints received and informal meetings and discussions with patients. It had an active PPG which included representatives from various population groups for example working age patients, and older people. The PPG last carried out a patient survey in 2013 and the practice revisited the findings in conjunction with the PPG as they remained current. The results and actions agreed from these surveys were available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt fully engaged with the practice who regarded them as an important reference group. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the National GP Patient Survey 2015 to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through daily discussions and meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. A PPG member told us the practice actively encouraged their feedback on experiences and they felt valued and supported both as a patient and critical friend. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and clinical meetings. We looked at three staff files and saw that all staff had received training, professional development and supervision. Regular staff appraisals had not been conducted but were scheduled including the formalisation of personal development plans.

Staff told us that the practice encouraged professional development and they valued the opportunity to attend clinical meetings with occasional guest speakers such as the community matron. It was an opportunity for the clinical team to meet together and explore clinical practice such as the review of significant events and guidance on providing treatments such as vaccinations to vulnerable patients. The meetings were minuted and clinical topics identified for subsequent meetings, staff were invited to conduct their own research ahead of the meeting to enable them to participate in the discussions.

The patients and clinicians benefitted from the GPs having Special Interests (GpwSI), these supplement their role as a generalist by providing an additional service while still working in the community. For example, Moulsham Lodge Surgery had GPs with special interests in gynaecology, ear, nose and throat, dermatology, gastroenterology and cardiology. This provided opportunities for other clinical staff to enhance their knowledge and skills whilst obtaining specialist advice and interventions for patients, where possible.

The practice had completed reviews of significant events and other incidents. These were discussed formally and lessons learnt shared in meetings and with the wider practice team to mitigate the risk of reoccurrences and improve outcomes for patients.