Cedar House Surgery

Quality Report

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Date of inspection visit: 21 April 2015
Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cedar House Surgery on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, 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, 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 difficult to get through to the practice on the telephone to book an appointment.
- 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 the management.
- The practice proactively sought feedback from staff and patients which it acted on.

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

Importantly the provider should:

Summary of findings

- Update the chaperone policy to include guidance for both clinical and non-clinical staff.
- Ensure records around received and distributed prescription stationery stock are clear
- Implement the recommendation resulting from the independent fire survey.

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, to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Suitable arrangements were in place to ensure all staff had the required recruitment checks prior to employment and these included DBS checks. There were enough staff to keep patients safe. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The practice was visibly clean and robust infection prevention and control procedures were in place. Staff had undertaken appropriate training to deal with medical emergencies, emergency medicines and equipment were securely stored.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it to improve their practice and patient outcomes. Patients' needs were assessed, 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, any further development needs had been identified and there were plans in place to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure effective case management of patients care. This included the community matron, pharmacist and hospital services.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients told us they were treated with compassion, dignity, respect. The patients told us they were involved in decisions about their care and treatment. Information to help patients understand the services were available in English and other languages appropriate for the languages spoken by the practice population. We saw positive examples to demonstrate how patients' choices and their preferences were valued and acted on. Staff treated patients with kindness and respect, and maintained confidentiality. Views from other health professionals we spoke with were very positive and aligned with our findings. The practice has outstanding policies and

Summary of findings

procedures that support patients receiving end of life care, these included two nominated GPs and a single point of contact out of hours for the families of those involved. The practice had received an award for palliative care for "Gold Standard Practice of the Year for palliative care from Management in Practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Regional Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with urgent appointments available the same day for all population groups. Some patients told us improvements were still required to improve telephone access, reducing waiting times and availability of non-urgent appointments with a named GP.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 records reviewed showed the practice responded quickly to issues raised. Staff acted on suggestions for improvements and changed the way they delivered services in response to feedback.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.There were systems in place to identify risks and improve the quality of services delivered. The practice is a current GP training practice and showed good levels of support towards its staff training all clinical grades including GPs, nurses and Health Care assistants.

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. There were home visits available for patients which were housebound. Consulting rooms were available on the ground floor for patients with limited mobility and there was a range of enhanced services available for housebound patients with good links into secondary referral. The patients we spoke to stated their care was considered, compassionate and appropriate for their needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions. The practice held a register of patients suffering with poor mental health and other long-term conditions. They held regular multidisciplinary meetings with other healthcare professionals to plan and coordinate care and treatment (a multi-disciplinary team is a team of health and social care staff. It includes professionals such as nurses, doctors, social workers, psychologists and benefits workers). Patients with diabetes received regular reviews of their condition by clinical staff. There is additionally a respiratory nurse who worked to a locally agreed set of medications and is supported in their function. The practice worked closely with the community nurses for patients with respiratory and heart conditions. Patients with palliative care needs were allocated a named GP who was responsible for their on-going care and support needs.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. A qualified paediatric nurse was available at the practice to provide specialist care and treatment for families and children. The practice held baby and immunisation clinics for children. There were evening family planning clinics available that patients could attend. The appointment system met the needs of families, children and young people. The practice had a designated child safeguarding lead who worked closely with the health visiting team. Regular safeguarding meetings were held at the practice and concerns cascaded to staff at weekly practice meetings.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age population. The practice offered late night appointments on a Wednesday and Thursday evening to enable access for those that work. Appointments could be booked on the day or in advance. Patients could see a GP of their choice and this provided continuity of care. The practice offered a choose and book service for patients being referred to secondary care. NHS Health checks were offered to patients between the ages of 40 and 75 with no pre-existing long term health conditions.

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 vulnerable patients including those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had a personalised care plan in place. It offered longer appointments for patients that needed them. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients 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 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. Patients experiencing poor mental health were offered an annual review of their physical and mental health needs. Patients were offered double appointments where required and were referred to other supportive services where appropriate. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. The clinical team worked with both the local children's mental health team and the older people's mental health team, we were told that there was difficulty referring to mental health teams from clinicians. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. The practice showed an on-going commitment to staff training and development in respect of mental health. The practice had a designated adult safeguarding lead and a communications strategy to ensure patients were protected.

Summary of findings

What people who use the service say

We spoke with ten patients on the day of our visit and two members of the patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. Prior to the inspection we provided the practice with CQC comment cards inviting patients to tell us about their experience of the practice. We reviewed 24 comment cards that were completed by patients who had recently used the service. We also looked at the results of the latest national GP patient survey before our visit.

The feedback and comments we received about the practice were predominantly positive about the service and staff. Patients told us that they were generally satisfied with the services they received. They told us the staff were friendly, helpful, that they felt listened to and involved in decisions about their care. This was also confirmed by the feedback from the national GP patient survey. However, two of the comment cards reviewed and patients we spoke with told us of the difficulties of getting appointments although they were happy with the care and treatment they received at the practice. This had been addressed in the recent past by installing further telephone lines and providing extra staff at critical times.

Areas for improvement

Action the service SHOULD take to improve

- Update the chaperone policy to include guidance for both clinical and non-clinical staff,
- Ensure records around received and distributed prescription stationery stock are clear.
- Implement the recommendation resulting from the independent fire survey.

Cedar House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP specialist advisor, a CQC inspector and a practice nurse specialist advisor

Background to Cedar House Surgery

The Cedar House Surgery is situated in St Neots, Cambridgeshire, just off the main high street. The practice is accessible by public transport (bus and train). The practice is one of 107 GP practices in the Cambridge and Peterborough Commissioning Group (CCG) area. The practice has a primary medical services (PMS) contract with the NHS. There are approximately 14,300 patients registered at the practice. The practice undertakes minor surgical procedures.

The practice has five partner GPs and four salaried GPs. One GP is designated as the senior partner. All partner GPs have lead responsibilities and management roles. There is a mixture of male and female GPs. The practice is also a training practice and trainee GPs work there on a short term basis carrying out consultations under the supervision of a one of the partner GPs.

The GPs are supported by a nurse consultant, five nurses and five health care assistants. There is a business support assistant and a number of support staff who undertake various duties. There is a reception manager and a team of receptionists. All staff at the practice work a range of different hours including full and part-time.

The surgery is open Monday to Friday between 8.30 and 6pm, there was an extended surgery until 8.15pm on two nights of the week. Surgeries run in the mornings and afternoons each day and the practice is closed at weekends. The practice has opted out of providing 'out of hours' services which is now provided by another healthcare provider. Patients can also contact the emergency 111 service to obtain medical advice if necessary.

There had been no information relayed to us that identified any concerns or performance issues for us to consider an inspection. This is therefore a scheduled inspection in line with our national programme of inspecting GP practices.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a representative of the patient participation group (PPG). 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 spoke with representatives from two of the care homes that were provided with GP services from the practice.

We carried out an announced inspection on 21 April 2015 at the practice. During our inspection we spoke with a number of GPs, a senior nurse, nursing staff, health care assistant administrative and reception staff. In addition we spoke with patients, the patients' champion, two members of the patient participation group and we observed how patients were cared for. We reviewed 24 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Incidents, accidents and national patient safety alerts, as well as comments and complaints received from patients were reviewed appropriately and learning was shared across practice staff.

The staff we spoke with were aware of their responsibilities to raise concerns and they knew how to report incidents and near misses.

National patient safety alerts were disseminated appropriately and GPs we spoke with were able to give examples of alerts they had recently acted on.

We reviewed safety records, incident reports and minutes of meetings where safety was discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw records where patients were given an apology when something had gone wrong. We examined the practice's records for the preceding 12 months and found the practice reviewed all of the complaints that were received and maximised the learning opportunity with conclusions being recorded.

The records provided a summary which included details of the incident, an investigation of events, how things could be improved, action taken and learning points for most of incidents, those without firm conclusions were still on-going.

We reviewed both clinical and administrative meeting minutes for the preceding 12 months. These demonstrated that complaints, incidents and significant events had been managed consistently and that learning had been disseminated to all appropriate staff.

Reliable safety systems and processes including safeguarding

The practice had a safe system to manage and review risks to vulnerable children, young people and adults. For example training records showed that all GPs and nursing staff had completed safeguarding training for children and the majority had completed training around safeguarding adults. Those GPs who had not yet completed training had courses booked in the near future. The GPs that had completed training in child safeguarding had completed courses to an appropriate level to enable them to undertake the role.

All staff we spoke with were aware who the lead GP was in relation to safeguarding and who to speak with if they had a safeguarding concern. The lead GP attended safeguarding update meetings and met with health visitors every four to six weeks to discuss individual cases. Every six months the lead GP met with school nursing staff to discuss safeguarding best practice involving school age children. We saw computer records with the alerts system for safeguarding displayed and we saw evidence of safeguarding being discussed within the clinical practice meeting. We were told that the child protection nurse (CPN) had discussions with the safeguarding lead every two weeks to support mothers during pregnancy.

The practice had safeguarding policies in place and staff had a clear understanding of these procedures. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. The majority, but not all staff were aware of their responsibilities to record and report safeguarding concerns, as well as share information with relevant agencies. The registered manager has agreed to amend the training to ensure all staff were aware of their responsibilities.

Contact details of the local safeguarding teams were easily accessible within computer records at the practice. There was a system of coding used by staff to highlight vulnerable patients on the practice computerised record system. This ensured that staff were aware of any relevant issues when patients attended appointments so they could be easily identified and offered additional support

We saw a chaperone policy that outlined practice policy in relation to training and procedures for clinical staff. A chaperone is a person who acts as a safeguard and witness, for a patient or healthcare professional during a medical examination or procedure.

The chaperone policy did not extend to non-clinical staff, yet we were told that on occasions non-clinical staff performed chaperone duties. We found that non-clinical staff had not received appropriate training for the role and their use was not documented in their chaperone policy.

Good

Are services safe?

This included whether a disclosure and barring service should be undertaken before being used as such. We discussed this with the practice on the day of the inspection and they have agreed to review their policy and training for non-clinical staff.

The practice chaperoning policy should be updated with these new sets of guidance so all staff are aware of their responsibilities and boundaries whilst safeguarding patients and /or their children.

Staff we spoke with who had been trained as a chaperone understood their responsibilities when acting as such, including where to stand to be able to observe the examination. They told us that they were always in view of the patient and could see any examination clearly. This protected both the GP and the patient. Patient records were updated to reflect that a chaperone had been in attendance at the consultation. A chaperone sign was clearly displayed in the reception area for the information of patients.

There was evidence of the practice taking a proactive stance to patient safety. As an example we were told of a healthcare assistant visiting a house bound adult patient where a correct medication regime was not being complied with by their carer. A safeguarding alert was raised and further clinical support from the GP was obtained, this resulted in additional training for the carer and the patient receiving support.

Medicines management

We checked medicines which were stored in the treatment rooms and medicine refrigerators and we found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures and which described the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry dates and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with published guidance and we saw a practice policy and contract for disposal of hazardous and non-hazardous waste.

Records we viewed reflected that the practice had a fault with a fridge at the branch surgery. The practice policy had been followed, medicines had been destroyed and the fridge replaced.

We found the nurses administered vaccines in accordance with legal requirements and national guidance. The nurse practitioner told us there was a protocol for repeat prescribing and we saw evidence of how the practice implemented this policy. We saw evidence that nurses and health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber. They received regular supervision and support in their role. There was a nominated GP who provided clinical advice to the nurses which in turn ensured that patients were given the best possible care.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescriptions not collected were also reviewed to ensure patients still required the medicines and were not at risk of their condition deteriorating without them.

The process for tracking blank prescription forms through the practice was not robust. Whilst printed blank prescription forms (FP10s) arrived at the practice and were signed as received. There was no onward audit trail which meant the practice could not reassure itself which GP or lead nurse had any particular set of blank FP10's. We also saw evidence of printed repeat prescriptions being left for the duty GP to sign and issue. These were kept in a staff only area, but there was a need to keep them more securely. Each repeat prescription was reviewed by a GP who checked patient details and blood test results and ensured that medication reviews had been undertaken or were planned. This helped to ensure that patients' repeat prescriptions were dispensed in line with legal requirements.

Cleanliness and infection control

The practice had a lead for infection control that had a clear understanding of infection control procedures. This enabled them to give advice on the practice infection control policy and carry out reviews as necessary.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control measures to reduce the risk of infection. The infection control policy included guidance

for staff in relation to hand washing techniques, fluid spillage and needle stick injuries; staff we spoke with were aware of the procedures to follow. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with appropriate hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We found that there was a ready supply of personal protective equipment available for staff to use and staff were able to describe how they would use these to comply with the practice infection control policy. These included disposable gloves, aprons and coverings.

All staff had received induction training on infection control practices that were specific to their role and refresher training updates in line with the practice policy. The immunisation status of staff including hepatitis B immunity was obtained as part of the pre-employment checks to ensure patient safety.

Cleaning schedules were in place that identified the areas to be cleaned, the materials to use and the cleaning frequency. Records we viewed reflected that cleaning was being undertaken as described and was being monitored. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be visibly clean and tidy.

We looked at a recent infection control audit which was supplied to us prior to the inspection. The audit was not dated, although we were told that it had been completed within the last six months. We saw that areas for improvement had been identified and relevant action had been taken. One example identified that the furniture in the waiting areas had a fabric covering and these had been replaced with chairs with a material that could be more easily cleaned.

Sharps bins were sited correctly, signed and dated. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection.

The practice had a policy for the risk assessment of Legionella (is a term for particular bacteria which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had the right type of equipment and in sufficient quantities to enable them to carry out diagnostic examinations, assessments and treatments. They told us that the equipment was tested and maintained regularly and we saw records that confirmed this. For example all portable electrical equipment was routinely tested and displayed stickers indicating the last test date. The practice had a policy for the maintenance and testing of equipment and we saw evidence this policy was complied with. We saw evidence of calibration of medical equipment such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out standards it followed when recruiting clinical and non-clinical staff. This policy included pre-employment checks and there was a check sheet at the front of each personnel file we viewed that had been completed. There was a wide range of appropriate checks in place such as confirmation of identity, Hepatitis B immunity, record of qualifications, references and records of continuing professional development.

We looked at staff records and these represented a cross section of the clinical and non-clinical staff employed at the practice. The records showed appropriate records for the staff during employment were on-going and included; registration with the appropriate professional body and criminal records checks for disclosure and barring service(DBS)

The business support assistant told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patient's needs. We saw there was a rota system in place to ensure there were sufficient numbers of staff on duty with an appropriate skill mix There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's absence through annual leave.

We saw that there was a staff policy in place and a rota that allowed a work life balance ensuring the staff were all rested and fit for work. We saw the rota had sufficient staff on duty and absences had been covered; for example we looked at a selection of periods within the last six months and found that planned staffing levels matched those on duty.

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running at the practice and there were always enough staff on duty to keep patients safe. We saw records that were used in relation to maintaining actual staffing levels and we found these to be appropriate to keep patients safe.

We saw that the practice had a policy for the use of locum GPs that included an induction process for them to follow. The policy outlined the use and training of locum GPs to ensure they were qualified, registered with their professional body and made aware of practice policies and procedures prior to commencing work.

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 checks of the building, the environment, electrical installations and fixtures. We saw the practice had a health and safety policy and staff told us they were aware of its contents.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health or medical emergencies. For example medical emergencies were responded to by the most appropriate team on duty at the time. There was an electronic method of summonsing assistance from other clinical teams. We saw appropriate emergency medicines were in place and the equipment they would use to respond was within expiry dates.

Records we reviewed showed all staff had received training in basic life support and cardiopulmonary resuscitation (CPR). Emergency medical equipment was available including access to oxygen and an automated external defibrillator(a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm)

All staff we spoke with knew the location of this equipment and records we reviewed confirmed it was checked regularly. The disposable items which were necessary for the safe use of both the oxygen and AED were in date and fit for purpose. These are delivery masks and tubing in the case of Oxygen and disposal pads in the case of the AED.

Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were all available in a secure area of the practice. Appropriate arrangements were in place to ensure emergency medicines were within their expiry dates and suitable for use. All the medicines we checked were in date and fit for purpose.

Arrangements to deal with emergencies and major incidents

We saw a business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified risks such as unplanned staff absences, adverse weather, loss of electricity and water supply. The mitigating actions for each risk were recorded to ensure staff were aware of how to manage risks. The plan also contained relevant contact details for staff to refer to. These included local Health Services and contact details for companies providing utilities such as gas and electricity.

The continuity plan we reviewed showed the practice had carried out a fire risk assessment in April 2014. The assessment detailed fire hazards within the practice, the risks and actions required to maintain fire safety. For example all staff had received fire awareness training and were familiar with fire evacuation procedures. This risk assessment identified the need for an external engineer to test the structural viability of the external fire escape; there were no records to show this had been completed.

Regular maintenance and testing of mobile and fixed fire equipment was also undertaken and this had been completed in February 2015. There was evidence of annual servicing of the fire alarm system and fire extinguishers as well as weekly fire alarm tests; these were completed on a zone by zone basis by the administration and nursing staff.

A staff communication system had been designed for use in the event of the practice being closed due to unforeseen circumstances. This allowed the practice to ensure continuity of service for patients for as long as possible and in spite of a range of issues, for example, adverse weather.

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) and from local commissioners.

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as dermatology, cryotherapy, minor surgery and family planning. We saw evidence that GPs within the practice were seeking second opinions which had the effect of reducing the need for secondary referrals especially in the case of dermatology.

We found the practice worked towards the gold standards framework for end of life care and maintained a palliative care register. Records reviewed showed that regular multidisciplinary meetings were held to discuss the care and support needs of these patients and their families. The meetings were attended by the GPs and community matron and for example dealt with any patients recently discharged from hospital so they were assessed according to need.

We found one example of outstanding practice in relation to the care and treatment received by patients with palliative care needs. A GP from the practice was available until midnight on each weekday; the out of hours service was able to contact them in relation to the care and treatment needs of their palliative care patients. This provided patients with additional support and demonstrated a caring response to patients in these circumstances. The practice had been awarded a gold standard for the practice of the year for palliative care by management in practice. We saw correspondence and gifts from families of patients that thanked GPs for their compassion and attention in these circumstances.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and improve the service.

The practice showed us four clinical audits that had been undertaken in the last year. We saw audits of referral rates for dermatology post dermatoscopy, minor surgery, care of the COPD Chronic Obstructive Pulmonary Disease- the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections), and prescribing antibiotics; all of the conclusions from these audits demonstrated effective care.

We found clinical audit work informed the GPs' prescribing practice to ensure they were offering care and treatment in line with best practice guidelines. Records were maintained to show how they had evaluated the service and documented the success of any changes. We reviewed data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was in line with expectations and showed no anomalies.

The practice had a repeat prescribing policy in place which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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, 98.8%% of patients on the practice diabetes register who had undertaken retinal screening in the past 12 months, this compares with the CCG average value of 85.9% and a NHS England value of 90.05%.The practice met all the minimum standards for QOF in asthma, cancer, epilepsy and chronic obstructive pulmonary disease (lung disease).

The practice made 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 audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

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 such as annual basic life support, information governance, safeguarding vulnerable adults and children. Records we viewed reflected that staff training was being monitored effectively.

We found the practice was committed to staff development and had an appraisal policy in place to encourage the evaluation of learning needs and monitor performance. All staff received annual appraisals that identified learning needs from which action plans were documented. The action plans were then used to assess a staff member's progress in achieving the targets and objectives that had been set for them. Our interviews with staff confirmed the practice was proactive in providing staff training. The practice had supported staff to undergo further training and to increase their skill levels; one of these staff being clinical and the other administrative.

The practice was a GP training practice and had a named GP responsible for mentoring new GPs The practice also accepted training nurses from the local university and showed us an example of a staff member that had progressed from administrative staff to Health Care Assistant.

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

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example the nurse practitioner regularly provided a ward round service to a local care home for patients with challenging mental health conditions. The nurse was able to telephone a named GP who was also available to attend and assist should the need arise.

Working with colleagues and other services

The practice worked with other service providers to meet patients needs and manage those of patients with complex requirements. It received blood test results, X ray results, letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care via a named GP. This GP was also the prescribing lead and monitored prescribing within the practice as well as attending meetings with the CCG on prescribing. From these meetings and email alerts they shared good practice, warnings and guideline changes with the rest of the team at the surgery.

We saw an effective culture of sharing information within the practice and staff we spoke with were able to explain how this took place. For example one GP was able to describe to us how they were updated with current guideline changes. The weekly practice meeting had standard agenda items which demonstrated this culture.

The practice held monthly multidisciplinary team meetings to discuss the needs of patients with complex needs, for example those with end of life care needs or children on the 'at risk' register. These meetings were attended by the community matron and palliative care nurses, as well as GPs. We saw that decisions about care planning were

documented in a shared care record. Staff we spoke with told us that this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

There was a multidisciplinary team (MDT) meeting held monthly where various clinical professionals discussed patients to ensure continuity of care. We also saw there were mechanisms in place to share information with 111(out of hours telephone advice) services. These enabled special notes to be placed on patient's files, for example with regard to safeguarding or palliative care.

We saw an effective range of internal meetings to share information and these included quarterly full practice, weekly management, monthly rota, monthly MDT meetings and safeguarding every four to six weeks.

Information sharing

The practice used several electronic systems to communicate with other healthcare providers. This included the electronic summary care record and the practice planned to have this fully operational by the summer of 2015. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours setting.

We saw an electronic system that allowed a special notes system to be added to the patient's notes to give GPs and other healthcare professionals' further information on patients, explaining some aspects of their care. We looked for example at a patient receiving end of life care where the special note was used to give contact details of the GP to be used up to midnight daily so they could provide continuity for the patient this in effect meant the family had a known GP as contact in the event they needed further support during the evening.

The practice had an electronic system to allow patients to use a "choose and book" system. This allowed patients to look at appointments when being referred to secondary care and to choose a location, time and day that suited them best. Staff we spoke with said this system worked well and reduced cancelled or non-attendance for appointments.

All staff we spoke with were fully trained on the electronic systems and were able to demonstrate effective use of all its functions.

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. 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 had a clear understanding of Gillick competence. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. As an example for all minor surgical procedures, written consent was obtained and 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 / 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.

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 smoking cessation advice to smokers and flu vaccinations to older people. Data available to us at the time of inspection showed the practice had given lifestyle advice in the last 12 months in relation to smoking cessation, safe alcohol consumption and healthy diet in 83.66% of patients with diagnosed hypertension (clinically high blood pressure). The local average for other GP practices was 74.45 % and the national average was 81.99% for this group of patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Good

Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for most immunisations was consistently above average for the local area, and a clear policy for following up non-attenders by the named practice nurse was in place. The practice, for example performed immunisations on 96.98% of patients in the 24 month age range, with the CCG average across the same group being 93.82%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with two patients on the day of our inspection and both told us they received very good service. These patients told us they were satisfied with the care provided, and said their dignity and privacy was respected. We observed positive interactions between staff and patients.

Patients also completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and the majority were positive about the service experienced. Most patients commented that the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Six comments were less positive and the common theme related to improving telephone access and the appointment system. This was also explained to us by a patient participation group member we spoke with. We saw that the practice had installed eight further telephone lines and provided extra staff at times of peak demand in response to these comments.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey and the practice own survey for 2013/14. The evidence from all these sources showed patients were satisfied with how they were treated, as an example 97% of respondents had confidence and trust in the last nurse they saw and 85% said GPs gave them enough time during consultations.

Staff and patients told us that all consultations and treatment was carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Curtains were provided in consulting and treatment rooms so that patients privacy and dignity was maintained during examinations, investigations and treatments.

There was a clear sign on reception that asked patients to respect others and allow conversations in private. If a confidential matter needed to be discussed patients could be taken into a separate room to maintain their privacy. A radio was playing in the reception area and this helped reduce the opportunity of conversations being overheard. We found that reception staff used a quiet tone to avoid being overheard as much as possible.

There was a touch screen available to avoid the need to speak on arrival and this was in an easily accessible location.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning, making decisions about their care and treatment; the surveys generally rated the practice well in these areas. For example, the 2014 national patient survey data showed 72% of practice respondents said the GP involved them in decisions about their care and 81% felt the GP was good at explaining tests and results. 83% said the last nurse they saw or spoke to was good at explaining tests and treatments, and 75% said the last nurse they saw or spoke to was good at involving them in decisions about their care.

The patients we spoke with 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 aligned with those views.

Patients had access to online and telephone translation services for those patients whose first language was not English. Staff told us they worked together with patients to ensure they were partners in their own care, particularly people with long term conditions those with mental health needs and those receiving end of life care. We spoke with a carer for a patient waiting for treatment who stated the practice was supportive and kind to its patients and involved them in their care and treatment.

Records reviewed showed monthly multi-disciplinary meetings were held to discuss the care needs and support required for patients on the palliative care register, as well as with their carers who were involved in any decisions made.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The 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, some patients told us they had received help to access support services to help them manage their physical and mental well-being. 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 told patients how to access a number of support groups and organisations. These included carer's direct, improving access to psychological therapies and bereavement. A system was in place to notify staff of bereavements so they could offer support to relatives when they attended the practice. The GP then based their response on individual cases and would either write or call the family of the deceased.

We spoke with a patient whose spouse had been very unwell having suffered a mental health crisis. This patient had praise for the surgery stating that not only had their spouse been treated well, but they felt the whole family had been supported.

The practice's computer system alerted GPs if a patient was a carer and a carer's register was maintained. This ensured carer's needs were reviewed and that written information was provided to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them by giving them advice on how to find a support service. This call was followed by a patient consultation at a flexible time and location to meet the family's needs.

We saw the practice had won an award from management in practice in respect of palliative care where the practice policy was to allocate a single GP with a second as a direct support. Records reviewed showed bereavement care, respite care and caring arrangements were discussed in relation to patients receiving end of life care and the support required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice responsive to people's needs; they had systems in place to maintain the services they provided which met the needs of their patients. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. We saw records of meetings where the practice had engaged with the CCG with regard to avoiding hospital admissions, these included comprehensive care plans and rescue medication especially for patients with respiratory conditions.

The needs of the practice population were understood and suitable systems were in place to address identified needs in the way services were delivered. The practice had developed a system of home visits using both the GPs and nursing staff. The nurses we spoke with said they felt supported in this role and they had developed an understanding of the needs of the patients that could be fed back to the practice. We saw an example of nursing staff visiting patients at home to complete tests that would normally have to be completed in hospital; these were completed on housebound patients avoiding unnecessary arduous journeys.

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). There were regular meetings between the practice and their PPG and we were told by members of the PPG that a GP always attended these meetings and they felt they were of value. We saw minutes of meetings where chairs in the waiting room and a blood pressure monitoring machine were discussed. The result of these meetings involved the PPG funding a machine which we saw available for patients to use in the waiting room.

We saw the practice facilities were appropriate for patients needs with adequate availability for consultation on the ground floor for patients with limited mobility. There were three waiting rooms which were clean and contained appropriate furniture. The consultation rooms were well equipped and all contained equipment that was necessary for examinations.

Tackling inequity and promoting equality

The practice had recognised the needs of different patients, including those in vulnerable circumstances in the planning of its services. The practice population were mainly English speaking, but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care. This translation service was available on the telephone, but we were told arrangements could be made if a translator needed to be physically present. There was a hearing loop available in reception for patients with hearing difficulties and there was a signing service available for those with reduced hearing. The reception staff routinely assessed patients' needs and gave double appointments if the need was identified.

The practice was accessible to patients with disabilities and those with prams. The practice was situated primarily on the ground floor and there was sufficient space within the waiting area, consultation rooms and corridors to manoeuvre a wheelchair. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. We saw there was a designated parking area for disabled patients in the practice car park.

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed the training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated by each member of staff.

The practice maintained a register of patients who may be living in vulnerable circumstances and had a system in place for identifying vulnerability in individual patient records. This included people with a learning disability, mental health needs and carers. Minutes of meetings we reviewed showed the practice worked in partnership with other health and social care professionals to support their needs. We spoke with the manager of a care home that the practice provided support to in terms of general health; this location had patients with challenging mental health issues

Good

Are services responsive to people's needs?

(for example, to feedback?)

and some patients had a reduction in their capacity to consent. The manager of the care home was complimentary about services provided by the practice and particularly by the nursing staff.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits, and how to book appointments through the website. The practice had suitable services in place to ensure different population groups could access appointments when necessary. For example, longer appointments were available for patients who needed them and those with long-term conditions. Home visits were offered to patients who were housebound due to illness or disability. This also included appointments with a named GP or nurse.

The practice was open between 8.30am and 6pm on weekdays, with the exception of Wednesday and Thursdays when the practice remained open until 8.15pm, we were told these late night surgeries were pre-bookable. There were arrangements to ensure patients received urgent medical assistance when the practice was closed and a contract was in place to support this function. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring dependant on the circumstances. Information on the out-of-hours service was provided to patients.

Most patients we spoke with were generally satisfied with the appointment system and the comment cards we received supported these findings. Patients confirmed they could see a GP on the same day if they were in urgent need of treatment and could pre-book GP appointments up to four weeks in advance. They also said they could see another GP if there was a wait to see the GP of their choice.

The practice's internal patient survey results for 2013/14 showed some respondents had difficulty in accessing the surgery by telephone to make an appointment; the practice acknowledged this feedback and installed eight additional telephone lines to improve the access. This was reflected in the national patient survey 2013-2014 where 53% of patients found it easy to get through to the practice on the telephone and 58% of patients described their experience of making an appointment as "good". Telephone access particularly in the morning and an increase in the availability of non-routine appointments were identified as areas for improvement.

This feedback was also reflected in the 2014 national patient survey results which showed patient access and the appointment system were areas requiring improvement. For example, out of 105 surveys received: 82% of respondents were able to get an appointment to see or speak to someone the last time they tried; 28% usually got to see or speak to their GP of their choice and 58% of respondents described their experience of making an appointment as good.

The practice staff were aware of this data and had monitoring systems in place to evaluate patient demand on the appointment system so as to inform service provision. This included working in partnership with the PPG to help improve the service (the PPG is a group of patients who work with the practice to discuss and develop the services provided) We saw practice actions plans identifying potential solutions to address these concerns.

We found that it was practice policy to offer same day appointments to all patients if appointments were available. There was a system in place to escalate from nominated to a GP who was duty for the day. When these appointments were full the patients were telephoned by a Doctor and if they needed to be seen that day they were placed on a standby list, these patients were then seen by any Doctor when they became available. This ensured that all patients that requested an appointment could be seen on the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The business assistant was the designated person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. This included posters displayed within the practice, patient leaflets and information on the practice website.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. We also saw minutes of meetings where the complaints and compliments had been shared with the patient participation group and

Good

Are services responsive to people's needs?

(for example, to feedback?)

discussed in order to identify areas for improvement. These had been appropriately sanitised prior to release to protect patient confidentiality. We looked at complaints received in the last 12 months, there had been 50 recorded complaints since April 2014 and we found they were satisfactorily handled and dealt within a timely way. Staff we spoke with told us of an open and transparent culture which was promoted when dealing with complaints.

Minutes of team meetings showed that complaints were discussed with all staff to ensure they were able to learn and contribute to determining any improvement action that might be required. For example GPs had been given feedback from a complaint where delays had been experienced in a secondary referral. We reviewed the complaints and found the vast majority were in relation to the appointments system originating from high demand and staff shortages.

The practice reviewed complaints annually to detect themes or trends. We looked at their annual complaints review report for 2014 -2015. The practice had identified that there was a trend in the number of complaints regarding access to appointments. We saw that the practice had discussed their action plan with the PPG and some measures to address this had been put in place and issued apologies where appropriate.

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. Their mission statement described that they placed patients at the centre of their care, with the intention of delivering a safe and effective service, being courteous, friendly, approachable, accommodating and continuing to improve services.

We spoke with 14 members of staff on the day of our inspection and they all demonstrated and understood the vision and values of the practice and knew what their responsibilities were in relation to these. Following our inspection we spoke with representatives from a care home where the practice provided care and support to patients and they confirmed that the practice worked in line with these values.

The practice vision and values included offering patient centred care and choice wherever possible as well as providing the best possible modern healthcare within available resources, whilst retaining the best features of a traditional family practice.

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 of any computer within the practice. There was an electronic storage system where staff could access the information they needed whilst restricting certain confidential information to nominated staff. We looked at 22 of these policies and procedures, and most staff had completed a cover sheet to confirm that they had read and understood the policies. All 22 policies and procedures we looked at had been reviewed and were up to date, staff we spoke with knew where to find these policies if required.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards, for example for 2013-2014 the practice achieved a QOF score of 100% compared to a national average of 96.48%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. A nominated GP was responsible for monitoring aspects of the QOF data supported by the business support assistant.

The practice had an on-going programme of clinical audit which it used to monitor quality and systems to identify where action should be taken. For example we saw an audit of prescribing antibiotics, the practice being slightly above CCG average in terms of their prescribing of this type of medicine. The use of the medicine was reviewed over a three month period and the cases looked into in detail. It was noted there was room for improvement and the lead GP in terms of prescribing continued to encourage practice compliance with national guidelines.

The practice had arrangements for identifying, recording and managing risks. We viewed records that addressed a wide range of potential issues, for example information governance, lone working and access to the building. Identified risks were discussed at practice meetings and where risk assessments had been carried out, action plans had been produced and implemented. The practice held monthly governance meetings and incorporated minutes from other administration and clinical meeting to inform the senior governance structure.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They told us flexible working patterns were in place to promote team working across all roles. They also said they enjoyed working at the practice, felt valued and knew who to go to in the management team with any concerns they had.

There was a comprehensive list of meetings that encompassed all relevant managerial functions for the practice and these fed into an overall governance meeting. We saw from minutes that practice meetings were held regularly, at least monthly. Staff told us there was an open and transparent culture within the practice, and they had the opportunity to raise any issues at these meetings. An assistant member of staff was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and confidentiality of records which were in place to support staff. Staff we spoke with knew where to find these policies if required and they were readily available for them to read.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys and an active Patient Participation Group. This group covered both the main and branch practice and is called the Cedar House and Dumbleton Patient Association, which was established in 2005. The practice used a variety of methods to advertise the activity of the group which for example included a noticeboard in the main waiting area, posters in the practice and attendance at certain clinics to promote the work of the group.

The group included a patient champion and 12 active members. Meeting regularly with the practice they raised funds and suggested improvements. Prior to our inspection we were provided minutes of meetings where suggestions were made to improve the patient experience and these were implemented by the practice.

We looked at the results of the national patient survey and found patients were satisfied with the service and the care they received. For example, out of 105 respondents: 80% felt the reception staff were helpful when they last visited the practice and 85% said the last GP they saw or spoke to was good at giving them enough time. In response to patient feedback, the practice had purchased eight additional telephone lines and engaged in a recruitment drive. The PPG has provided funding for the purchase of medical devices at the surgery to assist patients.

The practice had gathered feedback from staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff were aware of the whistleblowing policy and had no cause to use it.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

There was no NHS friends and family (March 2015) data available for the practice.

Management lead through learning and improvement

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

One non-clinical staff member had been supported to undertake a business course and explained how they had used their learning to identify and recommend areas within the business development side of the practice that could be improved. The practice was an established training practice, we saw a culture within the practice where clinical staff were encouraged to expand their competencies and offered appropriate support by the partners. This included providing opportunities to take study time during working hours.

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

We were told the practice had expanded though the years and operated a successful branch surgery. The main premises had become cramped and a lead GP had been proactive in looking at expansion projects, but these have been unsuccessful to date.

The lead GP engaged in meetings with other GP practices in the area to share potential future solutions in the provision of care.