Southgate Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Southgate Surgery on 25 March 2015. We visited the practice location at 137 Brighton Road, Crawley, West Sussex, RH10 6TE.

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 (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect.
- The practice understood the needs of the local population and planned services to meet those needs.
- The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being for patients.
- The practice engaged effectively with other services to ensure continuity of care for patients.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

- Staff felt well supported and described a culture of openness, transparency and continuous improvement.

We saw one area of outstanding practice:

- The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being within the local population. They had developed an ongoing programme of well-being events and activities in which patients were able to participate. For example, the practice had recently hosted a wellness evening which showcased how art, music and exercise could improve patients' health and well-being. The practice had also set up its own choir to encourage patients to sing and to highlight the benefits of singing to patients suffering from a range of conditions.

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

The provider should:

- Ensure learning from incidents is more comprehensively recorded and reflects how learning points identified are followed up.
- Continue to monitor and review patient feedback to ensure GPs involve patients in decisions about their care.
- Continue to review and implement improvements to patients' access to the practice by telephone.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had a good understanding of procedures relating to the safeguarding of children and vulnerable adults and staff had received training in adult and child safeguarding at a level appropriate to their role. Risks to patients were assessed and generally well managed. The practice had assessed the risks associated with potential exposure to legionella bacteria. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice promoted local support groups so that patients could access additional support if required. The practice had a designated carer support worker who worked within the practice on one morning per week to coordinate support for carers. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect. However, data indicated that patients did not always feel GPs involved them in decisions about their care and treatment. All of the GPs within the practice were aware of this feedback and had discussed the findings to determine ways in which improvements could be made. GPs we spoke with were able to describe ways in which they involved patients in decisions about their care and treatment.

Summary of findings

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. The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being within the local population. They had developed an ongoing programme of well-being events and activities in which patients were able to participate. Urgent appointments were available on the same day. However, some patients told us they experienced difficulty in accessing the practice by phone. The practice provided a system of GP led triage for patients before allocating an urgent appointment. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

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 clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older patients. 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 older patients in its population. The practice ensured early referral to services for memory assessment. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 years had a named GP. The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being for older patients. They had developed an ongoing programme of well-being events and activities in which older patients were able to participate. Flu vaccinations and health checks were available to older patients at weekends in order to allow family members to attend and to ensure the provision of adequate time to support those patients' needs. The practice had a designated carer support worker who worked within the practice on one morning per week to coordinate support for carers.

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. Care plans had been introduced to minimise the risk of unplanned hospital admissions. Longer appointments and home visits were available when needed. All of these patients had a named GP and a structured regular review to check that their health and medication needs were being met. Patients were sent reminder letters and text messages prior to their review appointments. 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. The practice worked closely with the local proactive care team, who were located within the practice premises, in the management of patients with long term conditions. The practice had developed an ongoing programme of well-being events and activities in which patients with long term conditions were able to participate. The practice had a designated carer support worker who worked within the practice on one morning per week to coordinate support for carers.

Summary of findings

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, for example, children and young people who had a high number of A&E attendances. Practice staff had received training in the safeguarding of children relevant to their role. All staff were aware of child safeguarding procedures and how to respond if they suspected abuse. Immunisation rates were relatively high for all standard childhood immunisations. The practice provided weekly immunisation clinics. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. 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 and health visitors. There was a midwife based within the practice. The practice worked closely with local schools to promote healthy living to children. They hosted visits to the practice by the school children during each year and undertook return visits to the schools to participate in health and well-being assemblies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours on one evening each week and on one Saturday morning each month to meet the needs of people who worked during the day. Early morning phlebotomy appointments were also available. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. NHS health checks were available to all patients aged from 45-74 years. The practice offered temporary registration to students who were living temporarily at the family home whilst on leave from university.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. Longer appointments were available to patients where needed, for example when a carer was required to attend with a patient. The practice demonstrated a strong commitment to tackling social isolation and promoting

Summary of findings

health and well-being for vulnerable patients. They had developed an ongoing programme of well-being events and activities in which vulnerable patients were able to participate. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had identified those vulnerable patients requiring support to minimise the risk of accident and emergency attendance and unplanned hospital admissions. Care planning was in place to support those patients. Patients receiving palliative care were supported by regular multidisciplinary team reviews of their care needs. The practice worked closely with a community pharmacist to ensure patients received delivery of medication to their homes where needed. 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). Patients experiencing poor mental health had a named GP and received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had identified a lead GP for the management of patients with dementia. It carried out care planning for patients with poor mental health such as dementia and learning disabilities. The practice undertook dementia screening of patients and ensured early referral to memory assessment services.

The practice had provided information to patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia. Longer appointments were available to patients if required. Carers of dementia patients were signposted to the practice carer support worker.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 20 comment cards all of which contained positive comments about the practice. We also spoke with ten patients on the day of the inspection.

The comments we reviewed were mainly positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. Five of the comment cards described the difficulty experienced in accessing the practice by phone at peak times during the day. Two of the comment cards highlighted the significant improvements seen within the practice over the last two years, particularly with regards to reception services provided. Patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were generally satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 79% of patients rated their overall experience of the practice as good. We noted that 95% of patients had responded that the nurse was good at treating them with care and concern. However, the survey found that just 65% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure learning from incidents is more comprehensively recorded and reflects how learning points identified are followed up.
- Continue to monitor and review patient feedback to ensure GPs involve patients in decisions about their care.
- Continue to review and implement improvements to patients' access to the practice by telephone.

Outstanding practice

- The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being within the local population. They had developed an ongoing programme of well-being events and activities in which patients were able to participate. For example, the practice had recently hosted a wellness evening which showcased how art, music and exercise could improve patients' health and well-being. The practice had also set up its own choir to encourage patients to sing and to highlight the benefits of singing to patients suffering from a range of conditions.

Southgate 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 and a practice manager specialist advisor.

Background to Southgate Surgery

Southgate Surgery provides general medical services to approximately 9,300 registered patients. The practice delivers services to a slightly lower number of patients who are aged 65 years and over, when compared with the national average. Care is provided to patients living in residential and nursing home facilities and one local hospice. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is similar to the national average.

Care and treatment is delivered by four GP partners and four salaried GPs. Six of the GPs are female and two are male. The practice employs a team of four practice nurses, one healthcare assistant and one phlebotomist. GPs and nurses are supported by the practice manager, a deputy practice manager, a practice coordinator and a team of reception and administration staff.

The practice is a GP training practice and supports new registrar doctors in training.

The practice is open from 8.30am to 6.00pm on weekdays. Extended hours consultations are available one evening per week from 6:30pm until 8:30pm and on one Saturday morning each month from 9.30am to 11.00am. The practice operates a flexible appointment system to ensure all patients who needed to be seen the same day are accommodated.

Services are provided from:

137 Brighton Road, Crawley, West Sussex RH10 6TE.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Crawley Clinical Commissioning Group (CCG). We carried out an announced visit on 25 March 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patient interaction and spoke with ten patients. We reviewed policies, procedures and

Detailed findings

operational records such as risk assessments and audits. We reviewed 20 comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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 database system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events were discussed at weekly clinical governance meetings and practice team meetings. We saw evidence of those meetings. We saw that records of incidents were completed in a comprehensive and timely manner and that there was appropriate action taken as a result. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms. However, the learning recorded was concise and did not always reflect how the initial learning points noted were followed up. There was evidence that the practice had shared the occurrence of incidents and the action taken, with relevant staff. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

GP and nurses were able to describe their involvement in significant events and incidents which had taken place and the learning involved. For example, the practice had recently identified delays in the processing of a referral of a young child to an external service and subsequent inconsistencies in the reporting of results. Learning from this incident meant that the practice had reviewed their procedures for the monitoring and follow up of referrals made to other services.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at regular clinical meetings to ensure all 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 in place to manage and review risks to vulnerable children, young patients and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff could demonstrate they had the necessary knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible within the practice.

Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic records. This included information to make staff aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans. The practice had identified a safeguarding administrative lead who maintained a register of all vulnerable children.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or

treatment. We were told that reception and administration staff had been trained to undertake chaperone duties. These staff had been subject to a criminal records check via the Disclosure and Barring Service.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services. The practice worked closely with the health visitor with whom they met on a weekly basis to ensure a regular exchange of information. The health visitor was informed when a child under the age of five years either left or joined the practice. Where children under five years of age failed to attend for scheduled appointments such as immunisations, the practice wrote directly to the parents and also informed the health visitor.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

Systems were in place to reduce the risks of the spread of infection. We observed the premises to be clean and extremely well maintained. We saw there were cleaning schedules in place and that daily cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control. They had received training to enable them to provide advice on the practice infection control policy and to carry out staff training. Infection control policies and procedures were in place. We saw that these had been reviewed in March 2015. An audit of infection control processes had been carried out in February 2015. All staff had received training in infection control processes and were aware of infection control practices.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available within the practice.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Good

Are services safe?

Suitable arrangements were in place to reduce the risks of exposure to Legionella bacteria which is found in some water systems. A comprehensive Legionella risk assessment had been completed and systems for the regular monitoring of water supplies were in place.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was recorded. We saw evidence that testing of electrical items and calibration of relevant equipment had been carried out in November 2014. For example, digital blood pressure machines and weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing and recruitment

Staff told us there were usually suitable numbers of staff on duty and that staff rotas were managed well. There was also a system for members of staff, including GPs and administrative staff to cover annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

We examined the personnel records of eight members of staff and found that the practice had ensured that appropriate recruitment checks were undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a comprehensive series of recruitment policies which set out the standards it followed when recruiting clinical and non-clinical staff. We saw that these policies had been reviewed in March 2015. The practice had undertaken risk assessment of all roles within the practice to determine the need for criminal records checks through the Disclosure and Barring Service (DBS). As a result, where required, staff had been subject to a criminal records check. We saw evidence of these checks.

Monitoring safety and responding to risk

The practice was located in modern, purpose built premises with good access for disabled patients. We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the defibrillator were checked regularly and sited appropriately.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included a fire risk assessment and the risks associated with exposure to legionella bacteria which is found in some water supplies. We saw that the latest fire safety risk assessment had been carried out in March 2015. The practice had a comprehensive series of health and safety policies. Health and safety information was readily available to staff.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered longer appointments when necessary.

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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Panic buttons were available within consulting rooms which staff were able to use in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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. Staff were able to give examples of occasions when they had responded to an emergency within the practice, such as a patient who had collapsed.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. We saw that the business continuity plan had been reviewed in November 2014 and the fourth version of the document was now in use.

Records showed that fire alarms were routinely tested. The practice had recently carried out a full evacuation of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurse practitioners that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and that these were reviewed when appropriate.

GPs within the practice held lead roles in specialist clinical areas such as diabetes and mental health. We spoke to one nurse practitioner who was the nurse lead for diabetes within the practice. They described a culture of continuous learning and improvement with encouragement to attend regular clinical meetings. The nurse practitioner told us that they attended a local diabetes forum and educational session every three months and as a result had developed relationships with local consultants with whom they were able to share and receive information.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. We saw that patients received appropriate treatment and regular review of their condition. The practice held a register of patients receiving end of life care and held monthly palliative care meetings with the local hospice team. Patients with palliative care needs were supported using the Gold Standards Framework.

The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions. The nurse practitioner told us that the practice provided support and review of patients with long term conditions according to their individual needs. The practice sent invitations to patients for review of their long term conditions. Home visits were provided by the proactive care team to patients who were housebound. Patients with long term respiratory conditions were offered additional support in managing their condition. The practice was able to refer those patients to a community respiratory team as required.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

For example, the practice had undertaken a completed audit cycle to review the prescribing of antibiotic medicines to treat patients with acute bronchitis. The audit had taken into consideration relevant NICE guidance and recommendations made by the British Thoracic Society in recommending the changes implemented. As a result of the audit the practice had reviewed its prescribing practices. The practice had also developed patient information leaflets in conjunction with the patient participation group to improve patient awareness and assist in the reduction of antibiotic prescribing for patients who may not need it. Other clinical audits undertaken included the review of patients for whom lifestyle intervention had been used to manage Type 11 diabetes and the prescribing of a particular medicine to treat patients with osteoporosis.

Good

Are services effective?

(for example, treatment is effective)

The practice achieved 99.3% of the maximum Quality and Outcomes Framework (QOF) results 2013/14. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 92.6%, with the national average being 93.5%. The percentage of patients with diabetes whose last measured total cholesterol was five mmol/l or less was 85.7% compared with a national average of 81.6%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Regular clinical meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around education, audit and quality improvement.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory training courses such as basic life support and training in adult and child safeguarding procedures.

The practice had identified GPs to undertake lead roles in clinical areas such as diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and had either 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 practice and remain on the performers list with NHS England).

Staff we spoke with told us they had participated in regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. This had included a detailed review of performance and the setting of objectives and learning needs. We examined eight personnel files which confirmed this. Staff described their appraisal as a useful and thorough process.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with one nurse practitioner who told us the practice supported education and ongoing professional development. They described a culture of continuous learning and improvement with encouragement to attend regular clinical meetings. The nurse practitioner told us that they attended a local diabetes forum and educational session every three months and as a result had developed relationships with local consultants with whom they were able to share and receive information. The lead nurse was encouraged to attend a local lead nurse forum on a six monthly basis and the whole nurse team regularly attended a local practice nurse forum. The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. The practice had access to the local proactive care team which was located within the practice premises. The proactive care team worked with people with long term conditions and their carers to actively promote health and wellbeing in the community and where possible prevent unplanned admission to hospital. The team included a social worker, community matron, prevention and assessment worker, occupational therapist, physiotherapist and community psychiatric nurse.

Multi-disciplinary meetings with local community teams were held regularly. An example of the range of patients discussed included palliative care patients, children of concern to health visitors, those experiencing poor mental health and 'at risk' patients including patients who had experienced or were at risk of unplanned admission to hospital.

Good

Are services effective?

(for example, treatment is effective)

The practice worked closely with local residential homes to provide care and support to the residents. For example, the lead GP within the practice was the named GP for one residential home which provided care to 31 patients with dementia. The practice provided a weekly visit to the home. GPs told us how they encouraged the completion of a care planning document entitled 'About Me' by the care home staff following each of their visits. This document encouraged accurate information sharing between family members, other carers and emergency services.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and action taken by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received.

Referrals were made using the 'Choose and Book' service. We saw evidence of the practice's referral process and its effectiveness. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice worked closely with the local pharmacist who provided prescription delivery services to ensure patients' needs were met. These included deliveries to patients' homes for older and housebound patients when required.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the 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. 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

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with more complex needs, for example dementia or long term conditions, 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.

Health promotion and prevention

The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being within the local population. They had developed an ongoing programme of well-being events and activities in which patients were able to participate. For example, the local community well-being team attended the practice on a weekly basis to provide activities for patients, such as chair based exercise sessions.

The practice patient participation group told us how they had been involved in supporting the practice in organising patient education and well-being events. The practice had provided a series of patient education evenings to provide information on subjects such as lifting for carers, head massage, diabetes and asthma.

Good

Are services effective?

(for example, treatment is effective)

The practice also worked closely with local schools to promote healthy living. They hosted visits to the practice for 90 children during each year and undertook return visits to the schools to participate in health and well-being assemblies.

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We noted that medical reviews took place at appropriately timed intervals. The practice carried out dementia screening and ensured prompt referral for memory assessment.

The practice had ways of identifying patients who needed additional support and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities, for whom they carried out annual health checks.

We noted a culture amongst the GPs and nurses of using their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. Three nurses within the practice were able to provide appointments for patients with minor ailments and had received appropriate training to support this role.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 96.5% of children aged up to 24 months of age had received their mumps, measles and rubella vaccination. This was equivalent to the clinical commissioning group regional average. Data we reviewed showed that 92.6% of patients with diabetes had a flu vaccination within the six month period between September and March. This was compared with a national average of 93.5%.

A wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and they were generally positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with ten patients on the day of our inspection. Patients we spoke with told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 79% of patients rated their overall experience of the practice as good. We noted that 95% of patients had responded that the nurse was good at treating them with care and concern, whilst 72% of patients reported that the GP was good at treating them with care and concern.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatment in order that confidential information was kept private. The main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. Some telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

We reviewed GP national survey data available for the practice. The patient survey information we reviewed showed mixed responses from patients to questions about their involvement in planning and making decisions about their care and treatment. We noted that 92% of patients had responded that the nurse was good at involving them in decisions about their care. However, the survey found that just 65% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%. All of the GPs within the practice were aware of this feedback and had discussed the findings within a team meeting to determine ways in which improvements could be made. GPs we spoke with were able to describe ways in which they involved patients in decisions about their care and treatment. For example, one GP explained the range of options they would discuss with a patient experiencing joint pain. Another GP told us how they would use open questions to explore the preferred treatment options of a patient with depression.

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.

The practice had recognised the ethnicity and diversity changes which had occurred within the local population. The number of patients with a first language other than English was increasing. Staff knew how to access language translation services if these were required. Staff within the practice were able to give examples of how they supported individual patient needs in order to promote equality. For example, five different languages were spoken across the practice team in order to provide support to individual patients.

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 72% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 95% of patients said the nurses were also good at treating them

Good

Are services caring?

with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported by the practice.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice had a designated carer support worker who worked within the practice on one morning per week to coordinate support for carers. The practice computer system alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

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 highly responsive to patients' needs. The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The needs of the practice population were well understood and systems were in place to address identified needs in the way services were delivered. The practice told us that the wellbeing of patients within the local community was their focus. They told us they viewed themselves as a community responsive practice.

The practice demonstrated a strong commitment to tackling social isolation and promoting health and well-being within the local population. They had developed an ongoing programme of well-being events and activities in which patients were able to participate. For example, the local community well-being team attended the practice on a weekly basis to provide activities for patients, such as chair based exercise sessions. The practice had recently hosted a wellness evening which showcased how art, music and exercise could improve patients' health and well-being. The event was supported by patients who were able to describe how their lives and well-being had been transformed by such activities. The practice had also set up its own choir to encourage patients to sing and to highlight the benefits of singing to patients suffering from a range of conditions.

The practice patient participation group told us how they had been involved in supporting the practice in organising patient education and well-being events. The practice had provided a series of patient education evenings to provide information on subjects such as lifting for carers, head massage, diabetes and asthma.

The practice also worked closely with local schools to promote healthy living. They hosted visits to the practice from approximately 90 children during each year and undertook return visits to the schools to participate in health and well-being assemblies.

The practice had reviewed the needs of its older patients and made changes to services to meet those needs. For example, patients over the age of 75 years were given the opportunity to access weekend appointments for their health checks. This enabled the practice to allocate more time for each appointment. The practice reported that they had recently identified three patients with conditions which required urgent attention as a result of those health checks.

The practice worked closely with local residential homes to provide care and support to the residents. For example, the lead GP within the practice was the named GP for one residential home which provided care to 31 patients with dementia. The practice provided a weekly visit to the home. Patients with dementia were well supported by the practice as staff had a good understanding of their needs. One GP within the practice was the lead for dementia across the local clinical commissioning group area. All staff within the practice had recently undertaken dementia awareness training.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The local proactive care team was based within the practice premises. The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The practice had an active patient participation group (PPG) which met regularly and with whom the practice worked closely. The practice also had a virtual patient reference group (VPRG). This group of patients did not meet but provided feedback to the practice by completing survey questionnaires. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that patients sometimes found it difficult to access the practice by telephone at peak times during the day. The practice had increased the administrative support allocated to the processing of GP-led triage calls each morning in order to reduce the length of time patients waited to get through on the phone. The practice had also introduced the booking of phlebotomy appointments via the practice website and

Good

Are services responsive to people's needs?

(for example, to feedback?)

intended to extend this system to other appointments in the future. The practice had introduced Saturday morning appointments on one morning each month in response to patient feedback that they would prefer additional opening times.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported.

The practice was located in highly inviting modern purpose built premises. The environment and layout had been designed with consideration to the impact of the surroundings on the healing and well-being of individuals. The use of colour had been selected to create both calming and stimulating areas within the practice. Seating within the waiting area was arranged in small circular groups to encourage communication. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and accessible front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Patient services were provided on the ground and first floor levels. Lift services were available to all floors. We noted there were car parking spaces for patients with a disability. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies. The practice provided a hearing loop for patients who experienced difficulty hearing.

The practice had recognised the ethnicity and diversity changes which had occurred within the local population. The number of patients with a first language other than English was increasing. Staff knew how to access language translation services if these were required. Staff within the practice were able to give examples of how they supported individual patient needs in order to promote equality. For example, five different languages were spoken across the practice team in order to provide support to individual patients.

Access to the service

The practice was open from 8.30am to 6.00pm on weekdays. Extended hours consultations were available one evening per week from 6:30pm until 8:30pm and on one Saturday morning each month from 9.30am to 11.00am. In the week where there was a Saturday morning clinic, the late evening clinic did not take place. The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations. Appointments could be booked in person or by telephoning the practice directly. Routine appointments could be booked up to two weeks in advance. Urgent same day appointments were booked following a telephone consultation with a GP. On-line appointments could only be booked with the phlebotomist. Repeat prescriptions could also be requested via the practice website. The practice acknowledged the difficulty experienced by some patients in accessing the practice by telephone at peak times during the day due to the high demand for appointments. They had taken steps to improve telephone and appointment access and continued to review patient feedback in this regard. The practice had implemented a dedicated appointment cancellation line which patients could ring to leave a message to cancel an appointment.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:00pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients on the practice website and in appointment information advertised in the practice.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet and website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever made a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. Complaints were discussed at clinical meetings, partners meetings and practice team meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity. The practice told us that the wellbeing of patients within the local community was their focus. They told us they viewed themselves as a community responsive practice.

We spoke with 16 members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

The practice had developed a clear strategy which was supported by a three year business plan which had been agreed two years previously. Business and service planning was carried out in conjunction with all stakeholders including staff of all levels and members of the patient participation group (PPG).

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed recently and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly GP partner meetings, clinical review meetings with GP's, nurses and healthcare assistants and regular team meetings which included administration and reception staff. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed.

We saw that records of incidents were completed in a comprehensive and timely manner and there was evidence of appropriate action taken as a result. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms. However, the learning recorded was concise and did not always reflect how the initial learning points noted were followed up. There was evidence that the practice had shared the occurrence of incidents and the action taken, with relevant staff. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, the practice had undertaken a completed audit cycle to review the prescribing of antibiotic medicines to treat patients with acute bronchitis. The audit had taken into consideration relevant NICE guidance and recommendations made by the British Thoracic Society in recommending the changes implemented. As a result of the audit the practice had reviewed its prescribing practices. The practice had also developed patient information leaflets in conjunction with the patient participation group to improve patient awareness and assist in the reduction of antibiotic prescribing for patients who may not need it. Other clinical audits undertaken included the review of patients for whom lifestyle intervention had been used to manage Type 11 diabetes and the prescribing of a particular medicine to treat patients with osteoporosis.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included a fire risk assessment and the risks associated with exposure to legionella bacteria which is found in some water supplies. We saw that the latest fire safety risk assessment had been carried out in March 2015. The practice had a comprehensive series of health and safety policies. Health and safety information was readily available to staff.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice. They had the opportunity to raise issues at any time with the GP partners and practice manager and were happy to do so.

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead GP for mental health and one GP

Are services well-led?

Good

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

partner was the lead for child and adult safeguarding. Staff were aware of the leadership structure within the practice. Reception, administration and nurses we spoke with were clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had an active patient participation group (PPG) which met regularly and with whom the practice worked closely. The practice also had a virtual patient reference group (VPRG). This group of patients did not meet but provided feedback to the practice by completing survey questionnaires. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that patients sometimes found it difficult to access the practice by telephone at peak times during the day. The practice had increased the administrative support allocated to the processing of GP-led triage calls each morning in order to reduce the length of time patients wait to get through on the phone. The practice had also introduced the booking of phlebotomy appointments via the practice website and intended to extend this system to other appointments in the future. The practice had introduced Saturday morning appointments on one morning each month in response to patient feedback that they would prefer additional opening times.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

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 spoke with sixteen staff and they confirmed they participated in regular appraisals which identified their training and personal development needs. Staff told us that the practice was very supportive of training and education.

Nursing staff reported that training was available in order for them to maintain and update their skills and they were well supported to attend training events. The practice had appointed a lead nurse who provided developmental support to the nursing team.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. For example, the practice had recently identified delays in the processing of a referral of a young child to an external service and subsequent inconsistencies in the reporting of results. The practice had as a result, reviewed their procedures for the monitoring and follow up of referrals made to other services.