Dr William Henry Andrew Walker

Quality Report

2 Chapel Lane
Toftwood
Dereham
Norfolk
NR19 1LD
Tel: 01362 691196
Website: www.toftwoodmedicalcentre.co.uk

Date of inspection visit: 11 November 2014
Date of publication: 22/01/2015

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

Dr William Henry Andrew Walker (Toftwood Medical Centre) has a practice population of approximately 3500 patients.

We carried out a comprehensive inspection at Toftwood Medical Centre on 11 November 2014.

We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the practice staff demonstrated enthusiasm and worked together in providing good standards of care for patients.

Our key findings were as follows:

- Practice staff worked together as a team to ensure streamlined patient care.
- There was a register of all vulnerable patients who were reviewed regularly.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received and access to the practice.

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. The services provided were safe and the practice had a good track record for safety. There was effective recording and analysis of significant events and lessons learnt were cascaded to all relevant staff for prevention of recurrences. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems had been arranged for safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure clinicians were up-to-date with both the National Institution for Care Excellence (NICE) guidelines and other locally agreed guidelines. Data showed the practice was performing well in following local Clinical Commissioning Group (CCG) guidelines and had audited areas of performance. Care and treatment was delivered in line with best practice. Systems were in place for regular reviews of vulnerable patients and those with long term conditions.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Reception staff treated patients with kindness and respect ensuring confidentiality was maintained. We observed staff interacting with patients in a caring and supportive way. Accessible information was provided to help patients understand the care that was available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Practice listened to and responded to the needs of their patients. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. There was a process which supported patients to raise a complaint. Complaints received were recorded, investigated and responded to in a timely way. The layout of the premises supported access for patients who had restricted mobility.

Summary of findings

Are services well-led?

Good

The practice is rated as good for proving well-led services. High standards were promoted by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice staff carried out proactive succession planning. There was constructive staff engagement and continuing efforts made to improve the service provision. The practice sought feedback from patients, which included using new technology, and had an active Patient Participation Group (PPG) who acted on behalf of patients and with staff in driving up the quality of service provision.

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. All patients aged over the age of 75 years had been informed of their named and accountable GP. Staff also encouraged patients aged 40 to 74 years to have a health check. Practice staff liaised closely with community professionals who, also regularly attended practice meetings to ensure the provision of up to date and appropriate care for these patients. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for care of people with long term conditions. Practice staff held a register of patients who had long term conditions and carried out regular reviews. For patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. The practice specifically reviewed all hospital admissions so that lessons could be learnt.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice staff worked with local health visitors in providing child immunisations. The nursing team offered immunisations to children in line with the national immunisation programme. Community midwives held regular ante natal and post natal clinics at the practice. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk.

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 this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. To accommodate the working age population there were extended opening hours with appointments from 7:30am with the nurse practitioner and a phlebotomist on Tuesdays and Wednesdays.

Summary of findings

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 had identified patients with learning disabilities and treated them appropriately. All patients with the exception of one in this group had received annual health checks. The nurse practitioner carried out annual checks of patients who lived locally in four care homes to promote their comfort in their own environment. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had been requested.

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). Care was tailored to patients' individual needs and circumstances including their physical health needs. Patients who presented with anxiety and depression were assessed and managed within with the National Institute for Clinical Excellence (NICE) guidelines. Annual health checks were offered to patients who had serious mental illnesses. Doctors had the necessary skills and information to treat or refer patients with poor mental health. Practice staff worked in conjunction with the local mental health team and community psychiatric nurses to ensure patients had the support they needed.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection. They informed us that staff were professional, polite and helpful. Patients told us they were given explanations so they understood about their health status and felt they were enabled to make decisions about their care and treatment. All patients spoken with reported they were happy with the standards of care they received. One patient commented that they had some difficulty in getting an appointment. Some patients said they waited a long time before they were seen but most others were happy with the waiting time.

Prior to the inspection we provided the practice with comment cards inviting patients to tell us about their care. We received 10 comment cards. Patients described their standards of care as being good to excellent. Patients commented that all staff were very caring and helpful; that staff always listened and spend the necessary time with them. Reception staff were pleasant, friendly and helpful both on the telephone and face to face. One patient informed us that they could not always get an appointment when they needed one.

We spoke with a member of the Patient Participation Group (PPG). PPGs are an effective way for patients and surgeries to work together to improve services and promote quality care. They told us that staff worked with them and that two senior staff attended the meetings. They told us they, and practice staff were positive about ensuring patients received good care and that there was a good liaison system in place. They also commented about the care they received as a patient. They told us they received the very best standards of care.

Dr William Henry Andrew Walker

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to Dr William Henry Andrew Walker

Toftwood Medical Centre served approximately 3500 patients.

At the time of our inspection there was one GP partner. There was also a salaried GP working at the practice. A salaried GP is a doctor who may later be made a partner. The GPs provided seven clinical sessions a week to meet patient's needs. There was a nurse practitioner, a practice nurse, a phlebotomist and a health care assistant who worked varying hours. Non-clinical staff included the practice manager, five receptionists and two administrators.

The practice offered a range of clinics and services including chronic disease management, diabetes, cervical smears, contraception, minor surgery, injections and vaccinations. Practice staff provided health advice to patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 November 2014. During our visit we spoke with a range of staff including two GPs, the nurse practitioner, the practice nurse, the phlebotomist, practice manager and two receptionists. We also spoke with 10 patients who used the service and a member of the Patient Participation Group (PPG) who acted as patient advocates in driving up improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. Relevant documentation was also checked. We observed how staff interacted with patients and how a GP responded to a request to attend the local care home to assess an ill patient.

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and appreciated the importance of reporting incidents. The practice manager recorded incidents and ensured they were investigated. The GPs held regular meetings to review the practice's safety record.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. The GPs held an annual meeting to review the practice's safety record over the previous year and to check that the actions taken had been effective.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff told us they recorded incidents as soon as they occurred. The practice manager formally recorded the incidents ready for investigations to be carried out.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw had been completed in a comprehensive and timely manner.

There was a process in place for dealing with medical alerts. The practice manager disseminated them to all clinical staff and if relevant, to non-clinical staff. If action was needed as a result of the alerts these were fully recorded. If they affected patient care a search of the respective patients would be carried out and where necessary, patients would be asked to make an appointment to have their care needs reviewed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records demonstrated that staff had received relevant role specific training on safeguarding children and adults. All staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

A GP and in their absence the nurse practitioner were designated leads in safeguarding for vulnerable adults and children and had been trained to level three (higher level). They demonstrated they had the necessary skills to identify abuse and take appropriate action. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible in the waiting areas. Chaperoning was provided by clinical and if they were not available, non-clinical staff carried out this role. Non-clinical staff had not received training. The practice manager told us that training for reception staff had been organised for the following month. We spoke with a receptionist who demonstrated they would carry out the role appropriately.

Medicines management

Vaccines were stored in lockable medicine fridges. Temperatures had been recorded daily. Staff ensured that vaccines were stored in line with manufacturer's instructions and were safe for administration.

Processes were in place to check medicines were within their expiry date and safe for use. All the medicines we checked were within their expiry dates. Emergency equipment was also checked to ensure it was in working order.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Cleanliness and infection control

Good

Are services safe?

All areas of the practice were clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. There as a cleaning schedule for staff to follow.

The practice had a lead for infection control who had received some training for this role and had made arrangements to obtain advice when they needed to. All other staff had received training in infection control.

The nurse practitioner had not made arrangements for regular auditing of the hygiene standards within the practice. Shortly after the inspection we received information that confirmed audit tools had been obtained and used to check the standards for prevention of infections. The information included evidence that clinical staff hand washing practices had been checked. As a result the nurse practitioner had made arrangements to discuss the findings during a clinical meeting.

An infection control policy and supporting procedures were available for staff to refer to; which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use. Staff confirmed there were always good stocks of PPE available within the practice. There was also a policy for needle stick injury.

We found that a Legionella risk assessment had not been carried out but we were told the premises did not have a header tank. There was a log and recordings made for the weekly flushing of taps and shower heads that were not in regular use.

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. All portable electrical equipment was routinely tested and appropriate recordings maintained. We were shown evidence of this.

Staffing and recruitment

Senior staff based the staffing numbers on their experience of how the practice operated. Consideration had been given to the access, care and treatments that patients required. The practice manager told us that a large number of staff worked part time and were willing to work extra shifts to cover staff holidays and other absences. There were occasions when locum GPs had been used to cover GP absences. However, a salaried GP was due to commence working within the merged practices and would spend part of their time at Toftwood Medical Centre.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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. Regular health and safety reviews had been carried out. The audits included action plans where improvements should be made. For example, discarding old equipment and replacing it. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency services who could provide assistance. Copies of the document were held off site by senior staff. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

Good

Are services safe?

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. Records that showed staff were up to date with fire training and that regular fire drills were undertaken. Risks assessments associated with the premises had been carried out.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These were held for staff to deal with medical emergencies such as a heart attack or severe allergic reaction. Staff had received training in how to treat patients who required urgent treatment whilst they were on the premises.

The patient leaflet and the telephone when the practice was closed gave information about how to access urgent medical treatment when the surgery was closed.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Care Excellence (NICE) and from local commissioners. Minutes of practice meetings demonstrated where the practice's performance and patients were discussed and any required actions agreed. The staff we spoke with told us these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. Discussions with the GPs and nurses confirmed that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We saw no evidence of discrimination when making care and treatment decisions. Our interviews with the GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The GPs told us they led in specialist clinical areas such as diabetes, family planning and prescribing. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and the actions taken if they required follow-up care.

Management, monitoring and improving outcomes for people

Practice staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care. The latest QOF data indicated that practice staff were meeting the national standards.

Practice staff had a system in place for carrying out clinical audits. One audit concerned a review of the prescribing of a medicine and the actions that had been taken as a result of the audit. Other audits concerning medicines were due to be repeated to monitor whether the improvements had been sustained. Another audit was carried out at the request of the CCG because it had been reported there was a high incidence of gastro-enterology referrals within the locality. The results showed that Toftwood Medical Centre had a lower than average referral rate and that GP's had followed local and national pathways when making referrals for this patient group.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. The practice also used the information they collected for the QOF register and their performance against national screening programmes to monitor outcomes for patients.

GPs, nurses and the practice manager held monthly clinical meetings. The discussions included a review of hospital admissions to ensure they were justified.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records provided evidence that all staff were up to date with attending the training courses such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Nurse's appraisals were carried out by clinical staff so that their practices could be discussed and checked. Speaking with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example specialist diabetes training for the practice nurse.

Working with colleagues and other services

There was evidence of appropriate multidisciplinary team working and it was apparent there were strong relationships in place. A multidisciplinary meeting was held every month to discuss patients receiving end of life care and those considered to be at risk. Community staff

Good

Are services effective?

(for example, treatment is effective)

attendance included Macmillan nurses, the community matron and district nurses. Regular contact was also maintained with health visitors so that children considered to be at risk were appropriately monitored.

Practice staff worked with other service providers to meet people's needs and manage complex cases. Test results, Xray results, letters from the local hospital including discharge summaries, out of hour's providers and the emergency service were received at the practice. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for taking any required action.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information sharing

Arrangements were in place that provided staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

The two GP's we spoke with told us they had good working relationships with community services, such as district nurses. There was good evidence of joint working relationships and their ability to make contact with each other at short notice when a patient's condition changed to enable provision of appropriate care.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications before they signed the consent form.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. GP's demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice manager told us all new patients were offered a health check by a practice nurse or Health Care Assistant. New patients who were receiving medicines were given an appointment with a GP to review the medicine dosage and if it was still appropriate. We overheard a receptionist providing comprehensive information to a new patient about the health checks they would undergo so they fully understood the process.

Patients who were due for health reviews were sent a reminder letter one month beforehand and asked to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. Clinical staff offered patients advice about maintaining a healthy lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff upheld and maintained the privacy and dignity of patients. We observed that when patients arrived staff greeted them in polite and helpful manner. All of the 10 patients we spoke with told us staff were friendly and professional towards them. They told us the reception staff were courteous and helpful.

The National Patient Survey results from 2013 informed us that most patients were satisfied with the service they received. For example, patients who described their overall experience as good or very good was 81.8 percent and the last time respondents wanted to see or speak with a GP or nurse was rated as 96.5 percent.

Window blinds and privacy screens were in each consulting room. The practice nurse told us they always closed the door before the consultation commenced. Patients we spoke with told us their privacy was always protected.

The practice had a chaperone policy and patients told us they were aware of their right to request a chaperone.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Reception staff told us they would offer to take patients into an unoccupied room if they needed to hold a confidential conversation. This prevented patients overhearing potentially private conversations between patients and reception staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, respondents said they were well informed about their care needs and able to make decisions.

Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and felt in control. Patient feedback on the comment cards we received was also positive and aligned with these views.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capability to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act. The practice manager told us they would make arrangement for all staff to receive training.

Patient/carer support to cope emotionally with care and treatment

We saw a dedicated notice board in the waiting area that provided information for carers. It provided details about and the contact details of three organisations that carers could approach for guidance and support. We saw a number of leaflets in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

The respective GP contacted bereaved families and offered them contact details of support agencies. We were told by reception staff that the GP may go out and visit the bereaved family or offered the opportunity for them to speak with the GP or a nurse whenever they wanted to. A patient we spoke with told us that staff had been very helpful during the initial period of their bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Practice staff recognised the needs of patients with long term conditions. For example, diabetes and asthma. The nursing staff took a particular interest in these groups of patients and had received specialist training in this aspect of care.

The Patient Participation Group (PPG) report for 2014 to 2015 indicated patients were satisfied with the service they had received. The PPG had met with senior practice staff to discuss the results of the survey and where improvements could be made. 52 percent of patients said they would prefer more on-line availability to book appointments. The practice manager had responded positively by increasing on-line appointment booking with all clinical staff.

Patients requiring specialist investigation or treatment were referred to hospitals. Patients we spoke with told us they had been given choices about where they wished to be referred to. Patients told us their referrals had been carried out effectively and promptly. There was also a 'choose and book' system so that patients could review the waiting times at various hospitals before making their decisions about where they wanted to be seen. Administration staff told us referral letters two days to send out and urgent ones on the day they were requested.

Patients who requested a home visit were contacted by telephone by a GP to check the visit was essential. However, if the GP had prior knowledge of the patient they may visit them at home without a telephone consultation. Home visits were made on the same day they had been requested. Regular home visits were made by GP's to patients who were housebound.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

Staff told us that translation services were available for patients who did not have English as a first language. The other language patients spoke was Portuguese and the touch screen for booking upon arrival at the practice had been adapted to include Portuguese.

The premises were accessible by patients who had restricted mobility. There was a toilet for disabled people. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. We spoke with a patient who told us they were able to manoeuvre their wheelchair and access the rooms they needed to go in. All consulting rooms were located on the ground floor.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

Appointments were available each weekday mornings and afternoons. Patients could make appointments from 8am to enable those such as working patients and children to attend before school hours commenced. The nurse practitioner and phlebotomist also offered appointments from 7:30am on Tuesdays and Wednesdays. We asked patients if they were able to access the practice when they needed to. They told us they were satisfied with the opening hours of the practice.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Some patients we spoke with told us they appreciated the on-line appointment booking system.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in

Are services responsive to people's needs?

(for example, to feedback?)

England and there is a designated responsible person who handles all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to.

The practice staff had a system in place for handling concerns and complaints. The summary of the complaints received during the last 12 months demonstrated that all complaints had been investigated, responded to and there were instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings.

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

At the time of the inspection the practice did not have a written business plan. We were told by the practice manager this was because they had concentrated their efforts in the recent merger with another local practice. We were told the practice had a vision to deliver high quality care and promote good outcomes for patients. It was evident that senior staff had continued to search for further areas of improvement on an on-going basis. Senior staff had developed a positive relationship with the Patient Participation Group (PPG). The member of the PPG we spoke with told us that they had communicated with patients well throughout about the recent merger.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they were encouraged to make suggestions that led to improved systems and patient care.

Governance arrangements

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 national standards. We saw that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes.

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. Senior staff regularly attended the CCG meetings to gain further insight for potential performance improvements. There were specific identified lead roles for areas such as prescribing and safeguarding. Responsibilities were shared among GPs, nurses and the practice manager.

The practice held regular governance meetings. We looked at the minutes from the last three meetings and found that performance, quality and risks had been discussed and actions identified.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP and nurse practitioner were the leads for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Records demonstrated that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The phlebotomist gave us an example of how other staff had learnt from them. It concerned the new needle equipment for taking blood samples from patients and ensuring safety to prevent needle stick injury. Staff we spoke with knew where to find policies if required to assist them in carrying out their role effectively.

At the time of our inspection the provider was not subject to any external peer reviews such as Urgent Health UK (UHUK).

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

The practice had an active Patient Participation Group (PPG). The PPG had carried out annual surveys and met every quarter. PPG's act as representative for patients and work with practice staff in an effective way to improve services and promote quality care. 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 are available on the practice website.

We spoke with a member of the PPG. They told us practice staff worked as team and the PPG had positive working relationships with staff. They informed us that staff made on-going efforts to improve the quality of the service and constantly searching for ways to improve staff practices.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files including the

Are services well-led?

Good

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

latest recruit and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and any requests they made.

The practice manager told us they regularly checked the appointments system to ensure there were enough to meet patient demands. Most patients we spoke with and the comment cards we received informed us they could get appointments when they needed them.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example, there had been a power failure to the vaccine fridge. Senior staff had contacted all the companies who had supplied the vaccines to determine risk clarification. Some vaccines were considered to be compromised and were discarded. Other vaccines were found to be safe for use. The findings were discussed with patients and their consent obtained before the vaccine was administered to them.