Fairstead Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Fairstead Surgery on 5 February 2015. The practice is led by the management team of Vida Healthcare who are the registered providers of Fairstead Surgery. There is a branch surgery located at St Augustine's Surgery, Columbia Way, Kings Lynn, Norfolk.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services and well led services. It was also good for providing services for the following population groups: older people; those with long term medical conditions; families, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

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

- Patients told us they were treated with compassion, dignity, care and respect. They were involved in decisions about their care and treatment and were happy with the care that they received from the practice.
- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- The needs of patients were understood and services were offered to meet these.
- The practice effectively used the benefits of being part of Vida Healthcare whilst retaining the individuality of being a small practice.
- There were a number of clinical teams who specialised in different areas, in order to provide a focussed and effective service to patients.

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should;

- Review storage and safety arrangements for all vaccines in the fridges.

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 report incidents and near misses. Lessons were learnt and communicated across the Vida Healthcare GP practices in the area, to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Staff had a clear understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs have been identified and planned for. Staff at the practice had received an annual appraisal. Multidisciplinary working to place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice in line with others in the same Clinical Commissioning Group (CCG) area, for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access for urgent appointments available the same day. However some patients raised concerns about appointment availability. The practice was well equipped to treat patients and

Summary of findings

meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff from the practice and across Vida Healthcare.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear vision and staff were aware of their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify and monitor risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG) and were supported by the practice. Representatives from this group were also involved in providing external oversight of the patient survey and results. Staff had received inductions, regular performance reviews and attended staff meetings and educational events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Staff had lead roles in chronic disease management and patients at risk of hospital admission were identified. All patients with long term conditions had structured reviews, at least annually, to check that their health and medication needs were being met. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available . For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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 appointments on Saturday mornings and one GP provided an open surgery one day per week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 70% of these patients had received a follow-up. A process was in place to follow up patients who had not attended for their appointment. We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example people who needed an interpreter, or had a learning disability. There were arrangements for supporting patients whose first language was not English.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice worked with other healthcare professionals including mental health crisis and counselling teams to support people experiencing poor mental health, including those with dementia. Patients with dementia were supported by the practice. They were given an annual review of their health and daily needs. There was liaison with the local dementia care services so that patients could be monitored in their own homes. Patients could be referred to the local drug and alcohol services to ensure they received appropriate support. The practice undertook meetings with local services and put systems and policies in place within the practice to identify those patients at risk of suicide or overdose attempts and provide rapid support and guidance.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and were registered as Dementia Friends. Mental health counselling was available weekly. Longer appointments were available when necessary. Partnership working was taking place to support patients and their carers.

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 27 cards that had been left for us and reviewed the comments made.

The majority of the comment cards we viewed contained complimentary comments about the GPs, nurses, reception staff and the services provided. Patients commented that staff generally were kind, caring and supportive. A few negative comments were made in relation to appointment availability and the time patients were kept waiting to see the clinical staff.

We spoke with eight patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. Patients did not feel rushed during consultations and they said staff were kind and caring. They told us that explanations were clear and care and treatment was delivered to a satisfactory standard.

The latest patient practice survey reflected that patients were generally satisfied with the services they provided, but some areas for improvement had been identified which were the subject of an action plan.

The patient had an active Patient Participation Group (PPG) that worked with the practice to discuss areas for improvement. This included face to face meetings and a virtual group whose views were sought by email. Regular meetings took place and they were kept informed about developments. The PPG was well supported by the practice with GPs in attendance. Information was updated on the practice website. PPG members and patients were given the opportunity to provide feedback about the services provided and contribute ideas for improvement.

Areas for improvement

Action the service SHOULD take to improve

Review storage and safety arrangements for all vaccines in the fridges.

Fairstead 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 second CQC inspector.

Background to Fairstead Surgery

Fairstead Surgery is owned by Vida Healthcare, a partnership made up of 20 partners who hold financial and managerial responsibility for six GP practices in Norfolk. At Fairstead Surgery there are four GP partners, nurses, a phlebotomist and a number of receptionists and administration staff. There is also a management team which includes a Chief Executive, a head of patient services, a head of people and governance, and a head of finance. There is a branch surgery which is located at St Augustine's Surgery, Columbia Way, Kings Lynn, Norfolk.

Fairstead Surgery, in the West Norfolk Clinical Commissioning Group (CCG) area, provides a range of alternative primary medical services across two sites to approximately 5,600 registered patients living in Fairstead and the surrounding areas. According to Public Health England information, the patient population has a higher than average number of patients under 18 compared to the practice average across England. It has a slightly lower proportion of patients aged over 65, 75 and a slightly lower than average number of patients aged over 85 compared to the practice average across England. Income deprivation affecting children and older people was slightly higher than the practice average across England.

The provider had declared non-compliance with the Health and Social Care Act 2008 in April 2008 relating to the suitability of their premises. This was confirmed during the Commissions last inspection in February 2014. The practice premises were cramped and offered little potential room for improvement or expansion. We saw that where necessary the practice had risk assessed and put systems in place to safely manage risks. Following our inspection we were told approval for newly built premises had recently been given. The head of people and governance told us the practice were now developing a new business plan to secure newly built premises close to the current location. The practice was located close to a local hospital and an A&E department.

The practice provides a range of clinics and services, which are detailed in this report, and operates between the hours of 8am and 5.30pm, Monday to Friday with extended hours opening on Saturday mornings from 9am to 12 midday for pre-booked appointments. Appointments are available on the day, or pre-booked up to one month in advance. One GP provides an open surgery once a week for those patients who wish to wait and be seen by him. Outside of practice opening hours a service is provided by another health care provider by patients dialling the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check

Detailed findings

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

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

How we carried out this inspection

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

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

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

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

Before inspecting, 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 inspection on 5 February 2015. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, reception and administrative staff and members of the management team. We spoke with patients who used the service and visiting health care professionals. We observed how people were being cared for and talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

We conducted a tour of the premises and looked at records and documents in relation to staff training and recruitment, and in relation to the safe maintenance of premises, facilities and equipment.

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example following changes to the electronic records system, staff had recognised that not all patient information had transferred correctly to the new system. This was brought to the attention of the management team and records had been audited and amended to ensure all patient data had been captured correctly.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated quarterly clinical governance meetings were held to review actions from past significant events and complaints. From this meeting any significant events or complaints where a learning need was identified were referred to the education team and an education meeting was arranged. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. We found staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example with a prescribing error for antibiotics, where the patients records' stated an allergy. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were disseminated to all clinical staff electronically and discussed at 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 to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. 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. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern.

Patient's 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 scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to

make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans, patients diagnosed with dementia or those requiring additional support from a carer.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that nursing staff were mostly used when chaperoning a patient. The practice was in the process of undertaking Disclosure and Baring Service checks for all non-clinical nominated staff who had received chaperone training. The management team told us these staff would not be used for chaperoning purposes until these checks had been completed.

Medicines management

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

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely in all instances. Medicines were accessible to staff but two pharmaceutical fridges with vaccines could potentially be accessed by patients. There was a process for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Daily temperature recordings were present and up to date.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, an antibiotic prescribed to a patient that was allergic to antibiotics.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were gradually being transformed to electronic versions, existing prescriptions followed national guidance and these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum. Spillage kits were available and staff we spoke with were able to describe to us how they would use them.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Good

Are services safe?

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However, we found there were limited notices about hand hygiene techniques displayed in staff and patient toilets. We discussed this with the management team who agreed to put these in place.

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers, nebulisers, ear syringes', pulse oximeters, blood pressure measuring devices and weighing scales.

Staffing and recruitment

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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The management team showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Staffing establishments including staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and appropriate levels of staff well-being

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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 example: there were emergency processes in place for patients receiving end of life care. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as staff illness, power failure or severe weather. The practice had plans in place to make sure they could respond to emergencies and major incidents. We were told these plans were reviewed on a regular basis.

Staff told us they felt happy they could raise their concerns with the management team and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

Emergency medicines and equipment were available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Good

Are services safe?

Staff confirmed if they had daily concerns or questions they would speak with the GPs, the management team or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinicians in the practice.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours

Arrangements to deal with emergencies and major incidents

We saw records which demonstrated that both clinical and non-clinical staff had received training in Basic Life Support within an appropriate time frame. All staff we asked knew the location of the Automated External Defibrillator and oxygen. Records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location.

These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff told us fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We found that clinical staff had a system in place to receive relevant updates about new guidelines and these were then put into practice to improve outcomes for patients. There were GP leads in specialist clinical areas such as dementia and learning disability. The nurses supported this work, but led on areas such as diabetic care, sexual health, family planning, childhood immunisations and respiratory care. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened.

Patients we spoke with on the day told us that they were satisfied with their assessments and felt that their needs were met by the clinicians. Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives. We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care. The practice ensured care plans were accessible to other agencies, such as out of hours services to ensure their full involvement and to facilitate sharing of information. The practice referred patients appropriately to secondary and other community care services.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included for example, data input, clinical review scheduling, and medicines management. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as asthma, diabetes and the latest prescribing guidance was being used.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from Vida Healthcare, areas of interest to them or 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, we saw an audit performed looking at the levels of recorded patient suicide and attempted overdosing. This had been undertaken from information received from the A&E departments to establish any trend and/or pattern. The audit identified gaps in the quality of communication and information received from the mental health team. The practice audit also identified gaps between the child and adult mental health services for teenagers. The practice undertook meetings with local services and put systems and policies in place within the practice to identify those patients at risk of suicide or overdose attempts and provide support and guidance. The practice also undertook a pilot scheme with the Samaritans to provide direct referral for vulnerable patients to help reduce the rate of suicide. Following a second review of the audit the practice continued to request regular contact with the mental health team at the practice multidisciplinary meetings to discuss individual cases. The practice also attended the West Norfolk CCG meeting with the Mental Health Foundation to discuss service provision.

We saw that following audit, the outcomes and actions were discussed with the practice team. Depending on the

Good

Are services effective?

(for example, treatment is effective)

relevance of audits and the learning outcomes we saw that these were also discussed at the six to eight week clinical practice meetings. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 70% of patients with learning disabilities had received an annual health and medication review.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

Effective staffing

Practice staffing included clinical, managerial and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. 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 received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed these included reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as adult and child safeguarding.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, practice nurses provided asthma and chronic obstructive pulmonary disease (COPD) monitoring and administration of childhood and travel vaccines. We saw that the practice nurses and healthcare assistants had been provided with appropriate and relevant training to fulfil their roles.

Reception and administrative staff had undergone training relevant to their role. Staff described feeling well supported to develop further within their roles. We noted a good loyal skill mix among reception, administrative and clinical teams.

Working with colleagues and other services

The practice worked with other service providers to meet patient's' needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from

Good

Are services effective?

(for example, treatment is effective)

communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team (MDT) meetings every fortnight to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We were told the practice worked closely with the community care coordinator who liaised with other services and coordinated attendance at MDT meetings.

Additional services were also provided at the main and branch surgery by visiting health care professionals, these included midwifery services, drug and alcohol clinics and counselling services. The practice branch surgery provided access for patients to the ABC team. ABC team is a local support organisation working within VIDA Healthcare, providing vulnerable patients, carers and families with support, signposting to other services and guidance. The practice worked closely with the team ensuring vulnerable patients were referred for additional support. The team had systems in place to assist, guide and signpost patients, carers and their families to support services. For example social services, benefits advice, assistance with shopping and other support services to enable patients to remain independent and in their home. The team were also qualified to undertake early screening for dementia and were able to describe examples of how they communicated and worked closely with the practice and other services to ensure a care plan and support services were in place to support vulnerable patients.

The Norfolk Recovery Partnership ran community based support for patients with drug and alcohol needs. Patients could be referred by a GP to ensure they received appropriate support. The practice undertook meetings with local services and put systems and policies in place within the practice to identify those patients at risk of suicide or overdose attempts and provide rapid support and guidance.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The staff told us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw that the practice had a register of patients diagnosed with dementia. Each of these patients had a care plan and of those patients 90.9% had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

Staff showed us and told us about the new patient's registration pack which included a new patient health questionnaire, a patient ethnic origin questionnaire, an alcohol users and smoking questionnaire, a medication information questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40 to 75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was monitored and data reflected that targets were being achieved.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Immunisation rates were relatively high for all standard childhood immunisations. The practice was pro-active in identifying patients, through posters in the surgery, the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available. There was a clear policy for following up non-attenders.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients; their relatives and carers to organisations such as ABC (a local support organisation working within VIDA Healthcare, providing vulnerable patients, carers and families with support, signposting to other services and guidance) and Help the Aged. A member of the ABC team attended the branch surgery to provide support and advice for patients and their carers. The practice kept a register of all patients with dementia and 90.9% had received an annual review. Staff were all registered as Dementia Friends. Dementia Friends learn about what it's like to live with dementia, this understanding is then used to assist people with dementia in their daily lives. This could be anything from helping someone find the right bus or supporting them as a patient when they arrive at the practice. The practice also kept a register of all patients with learning disabilities and 70%

Good

Are services effective?

(for example, treatment is effective)

had received an annual health check. The Norfolk Recovery Partnership ran community based support for patients with drug and alcohol needs. Patients could be referred by a GP to ensure they received appropriate support.

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards and information monitors in the reception area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a clear person centred culture at the practice. Staff and management were committed to working in partnership with patients. During our inspection we observed that patients were treated with respect and dignity during their time at the practice. All of the patients we spoke with, and received comments from during the inspection made positive comments about the practice and the service they provided. Patients reported that all the staff were helpful and very friendly. We were told they were happy with the treatment and care they received.

We were told that although space was limited at the practice, facilities could be made available for patients to talk confidentially when they were at the reception desk. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their role in relation to confidentiality.

We saw that patient's confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey, which was published on 8 January 2015 and a survey of 109 patients undertaken by the practice's Patient Participation Group (PPG) during 2013 to 2014. The evidence from both of these sources showed patients had mostly positive levels of satisfaction with the service provided. The PPG survey showed satisfaction with dignity and respect, appointment satisfaction and prescription requests. The National GP Patient Survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (98%) and by their GP (78%). 83% of patients reported that the reception staff were helpful. In relation to whether staff listened to them 93% reported this being good for nurses and 73% for GPs. All of the respondents reported that they had confidence and trust in the last nurse they saw and said they were good at giving them enough time. 87% had confidence and trust in the last GP they saw and 82% said the GPs were good at giving them enough time. Most of these results were average when compared with other practices in the Clinical Commissioning Group (CCG) area. However, only 67% described their overall experience of the practice as good and 54% of patients stating they would recommend the practice. A reported rate of 8% describing their overall experience of the practice as poor and 33% responding they probably or definitely would not recommend the practice. This showed the practice had a higher dissatisfaction level than the CCG average of 2% for poor overall experience and 2% for probably would not recommend their practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the service experienced. Patients said they were happy with the care and treatment they received and felt the practice offered an excellent service. They made positive comments about staff and said they were friendly, efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive and raised concerns about the availability of appointments. Two other cards were positive but also expressed concerns about appointment availability with one card stating if it was hard to get an appointment they preferred to go to the local A&E department and wait for three hours. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients'

Good

Are services caring?

privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed this has been discussed.

Care planning and involvement in decisions about care and treatment

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. One patient told us they didn't feel they were being listened to. Other patients 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, 24 out of 27 accounts aligned with these views. However one card was incomplete, the remaining two comment cards completed by patients did not remark on their care or treatment.

Staff told us that translation services were available for patients who did not have English as a first language. All staff we spoke to were aware of different services available and explained they had been used in the past, for example phone translation services and on-site translators.

Patient/carer support to cope emotionally with care and treatment

Patient feedback on the comment cards was very positive regarding the care staff showed to patients and their carers. Staff we spoke with showed awareness and empathy for patients, they were able to describe to us and we saw examples of how they supported patients when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

The practice had a system for ensuring that all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. Patients were supported by the practice when a close relative died. The waiting area included information sign posting people to support available including citizen's advice, counselling and bereavement services. A named GP visited patients towards the end of their lives and supported family members alongside the community matron and nursing team. Traumatic events such as a death or loss of a child during pregnancy were identified and support offered including signposting to other services. If the service was unable to meet the patient's needs they could refer the patient to trained counsellors and mental health support. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We didn't speak to any patients who had recently experienced bereavement, however those we did speak with told us the practice provided good support and staff were helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. We found that the practice understood the needs of the patients using the service and the services were tailored to patients' needs to ensure flexibility, choice and continuity of care.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Patients could request to see a GP of their choice and this was accommodated on most occasions. Open surgeries were held one day a week by one GP, to provide ease of access. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of 10 minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed. This was confirmed on many of the comment cards we received.

The practice was prepared to implement suggestions for improvements and make changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). The PPG informed us that the practice had introduced shoe horns to aid the elderly with putting their shoes back on following consultation. The PPG also told us the GPs and practice staff actively participated in "health fairs", daily events organised twice last year by the PPG, to inform the public and patients of general wellbeing and to answer any health related questions. The lead GP started a slimming group to attract other patient groups into interaction with the practice and PPG, but attendance to this was not very successful and eventually had to be disbanded.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours. There was a palliative care register and the practice undertook regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They provided temporary resident status for travellers, ensuring them access to care. Special drop-in clinics were available for carers on a monthly basis to provide support and guidance. Staff had access to an interpretation and translation service. The practice website offered translation facilities for 90 languages. The appointment check-in facility in the practice was set up to reflect the most common languages in the area. Staff we spoke with were knowledgeable about language issues and described how they would access an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. We saw evidence of staff supporting people who were unable to use the booking in screen.

We saw that the waiting area was able to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice consultation and treatment room were situated on the ground floor of the building enabling access for patients. However corridors around the building were narrow. This made access to some rooms quite difficult for patients who used a wheelchair or for people pushing prams or buggies. The premises benefitted from public parking facilities and there was step free entry access suitable for wheelchair users.

Access to the service

Appointments were available from 8am to 5.30 pm on weekdays. The practice offered extended opening Saturdays mornings from 9am to 12midday for pre-booked appointments. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they

Good

Are services responsive to people's needs?

(for example, to feedback?)

should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Patients were able to register to receive information by text message on their phone regarding appointments and health care.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice had recognised the needs of different groups in the planning of its services. They provided temporary resident status for travellers, ensuring them access to care. Special drop-in clinics were available for carers on a monthly basis to provide support and guidance.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments cards received from patients and patients we spoke with showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Of the 27 cards received one card was blank, one card expressed concerns at not getting an appointment with a clinician of choice and another reported 'difficulty for urgent appointments'. One card stated that if it was hard to get an appointment they preferred to go to the local A&E department and wait for three hours. The practice was situated close the local A&E department at the Queen Elizabeth Hospital (QEH). Due to some patient's attendance at the local A&E during practice opening hours, the practice was working closely with other organisations, such as Monitor and NHS England to reduce the high demands and impact on the A&E department at QEH. One GP told us how they held an open surgery one day a week to ensure their patients were able to access them. Patients we spoke with were happy to sit and wait to see this GP.

The practice's extended opening hours on Saturday mornings. The appointments were introduced for people with long term conditions for medication and health reviews who had work commitments during the week. Patients had told the practice that they were useful especially due to being available by pre-booked appointment.

The practice endeavoured to see dementia patients on time to reduce anxiety and stress to them caused by waiting. It carried out advance care planning for patients with dementia. 90.9% of patients experiencing dementia had received an annual physical health check.

The practice premises were cramped and offered little potential room for improvement or expansion. We saw that where necessary the practice had risk assessed and put systems in place to safely manage risks. Following our inspection we were told approval for newly built premises had recently been given. The head of people and governance told us the practice were now developing a new business plan to secure newly built premises close to the current location.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet and on the practice website.

We looked at seven complaints received in the last 12 months and found that no trends had been identified. However, lessons learnt from individual complaints had been acted on in a timely manner with learning outcomes cascaded to staff within the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included a focus on holistic health care.

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

Staff showed us plans and documents evidencing that the practice was in the process of implementing a customer service approach to dealing with patients in the administrative and front office side of the practice, to improve customer care and patient relations.

Governance arrangements

The practice was led by the management team of Vida Healthcare who were the registered providers of Fairstead Surgery. They had dedicated GP and managerial leads responsible for governance. There were clear identified lead roles for areas such as information governance, safeguarding, complaints and training. The practice held a monthly clinical governance meeting, where they discussed clinical governance issues which included updates from areas of risk, complaints and significant events. We looked at minutes from the previous meetings and found risks had been discussed as well as quality and performance.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures, but there was no evidence available to confirm when staff had read the policy and if they had understood it. All policies and procedures we looked at had been dated and reviewed, but did not display a next review date. The head of people and governance informed us that, because of the take-over by Vida Healthcare, policy updating was in progress. We noted that information about policies and procedures was part of the induction process for new staff. Staff we spoke with knew where to find the policies and were able to describe who they would go to for support and guidance should they need it.

The practice sought external overview and scrutiny in relation to complaints and significant events. We were told that themes and learning identified and completed as a result of complaints and significant events, were shared at a 'primary care group' meeting, on a six monthly basis. This group was made up of representatives from the Patient Representative Group and clinical and managerial staff.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QOF data was regularly discussed at clinical team meetings and plans were agreed to maintain or improve outcomes for patients. The QOF data for this practice showed it was performing in line with national standards.

Leadership, openness and transparency

We were shown 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 lead for safeguarding, within the practice and within Vida Healthcare. Clinical staff also had lead roles in relation to their clinical expertise. There was a lead GP for a number of medical conditions for example asthma, diabetes and women's health. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice for other areas.

We saw from the minutes we looked at that staff meetings were held regularly. We spoke with eight members of staff who told us that felt valued, well supported and knew who to go to in the practice with any concerns. 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 or clinical meetings as appropriate. There was a willingness to improve and learn across all the staff we spoke with. Staff told us they felt the leadership in place at the practice was consistent and fair and generated an atmosphere of team working.

Seeking and acting on feedback from patients, public and staff

The practice had an active Patient Participation Group (PPG) with a steady membership of patients. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. The PPG included limited representation from all population groups; it was mainly representative for the patient group of older people. We were told the PPG had attempted to attract other patient groups repeatedly through open days, leaflets and word-of-mouth, but had

Are services well-led?

Good

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

received a poor response rate. The PPG informed us they met every one to two months and at least one or two GPs would always attend and listen to feedback. The PPG had attempted to carry out surveys, but felt they did not receive enough feedback for accurate analysis. The members of the PPG we spoke with told us that they found the practice were open and answered questions directly and openly. For example, we were told that the practice patient surveys were planned and shared with the group. Suggestions for items to be included in the survey were discussed and where appropriate agreed for inclusion in the survey. Members of the PPG joined staff to hand out surveys to patients during the practice flu clinics to assist with the completion and encourage patient feedback. We saw the collated results were then presented to the group for discussion and approval. We saw that improvements had been made following feedback from the patient's survey completed in 2014. These included; communicating survey results to staff for them to contribute their ideas, actively try to recruit more members to the PPG, introduce a virtual PPG to see whether a greater variety of groups can be represented and share their opinions in the running of the group. The PPG representatives we spoke with told us they felt they were able to make suggestions and express their views to the practice and that these were taken seriously and listened to.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were told how staff had recognised issues with the changeover of the electronic systems software and the potential loss of patient information. Staff told us the issues were identified and taken to the management team who put actions in place to rectify the problem. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

The practice had a culture which enabled learning and improved performance. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality, safe and effective care. Vida Healthcare were recognised as an investors in people organisation. We were told this ensured the organisation provided well-trained, motivated staff to deliver its services. Investors in People is a management framework for high performance through people. Accreditation is recognised in industry as a mark of excellence.

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. In addition to their mandatory training they were supported to attend study days each year to undertake training in areas of their specialist interest. This enabled clinical staff to meet the revalidation requirements for their professional registration.

We were told by a number of staff that the practice participated in 'time to learn' sessions quarterly. Training was arranged by the Vida Healthcare or training was undertaken within the practice according to the needs of the practice staff. We reviewed four staff files and saw evidence that appropriate training had been undertaken by staff. We saw that regular appraisals had been undertaken which included a personal development plan.

There was a strong focus on clinical excellence and training and support for clinical staff. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed. The practice had completed reviews of significant events and other incidents and complaints and shared with staff in meetings and away days to ensure the practice improved outcomes for patients. Records showed that regular clinical and non-clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Where audits had taken place these were part of a cycle of re-audit. Completed audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment.