Dr Bose & Partner

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 2 December 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The appointment system was responsive to the needs of the patients. This ensured patients were able to access same day and emergency appointments.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- Staff were all clear about their own roles and responsibilities, and felt valued, well supported and knew who to go to in the practice with any concerns.

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

The provider should:

- Complete a risk assessment to identify a list of emergency medicines that the practice needs to stock.
- Provide staff who act as chaperones with appropriate training.
- Ensure all staff receive personal development and support.
- Record all discussions and actions to be taken from practice meetings.

Summary of findings

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 practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people 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. Data showed patient outcomes were above average for the locality. Patients'' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. Appraisals and the personal development plans were in place for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the locality for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice. They confirmed that they were usually offered a same day appointment when they telephoned, and could also book appointments in advance. The practice offered extended hours three evenings a week. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

Summary of findings

There was an accessible complaints system and evidence which demonstrated that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a strong and visible leadership which was well supported by the staff team. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active Patient Participation Group (PPG). Staff had received inductions and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice had identified vulnerable older patients and had developed individual care plans to support their care needs. These care plans were shared with the out of hours provider, with patients' permission. Influenza and shingles vaccinations were offered to older patients according to national guidance. Home visits for vaccinations were arranged for older patients who were housebound.

People with long term conditions

Good

The practice is rated as good for people with long term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. The practice maintained registers of patients with long term conditions. Individual care plans had been developed to support their care needs. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks at a time suitable to them. Staff were proactive in following up patients who did not make appointments for their reviews.

Families, children and young people

Good

The practice is rated as good for families, children and young people. We saw that the practice provided services to meet the needs of this population group. Urgent appointments were available for children who were unwell. Staff were knowledgeable about how to safeguard children from the risk of abuse. Systems were in place identifying children who were at risk, and there was a good working relationship with the health visitor attached to the practice. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice. New mothers and babies were offered an integrated eight week check, at which they saw the GP, practice nurse and health visitor. Antenatal clinics were also held at the practice.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those who have recently retired and students). The practice offered a range of appointments which included on the day and pre-bookable appointments. The practice offered extended hours three evenings a week. The practice was pro-active in offering on line services as well as a full range of health promotion and screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 75 years old a health check with the practice nurse. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

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. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence, including looked after children, asylum seekers and people with a learning disability. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and Healthy Minds.

Summary of findings

What people who use the service say

We spoke with six patients on the day of the inspection. Patients were very satisfied with the service they received at the practice. They told us they could get an appointment at a time that suited them, including same day appointments. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed the 16 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all comments were extremely positive. Patients said they felt the practice offered an excellent service, and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. They told us the appointment system was easy to use and met their needs.

We looked at the national GP Patient Survey published in December 2013. The survey found that 93% of patients rated Dr Bose and Partner as good or very good, which placed them amongst the best practices. The results showed that 84% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

Complete a risk assessment to identify a list of emergency medicines that the practice needs to stock.

Provide staff who act as chaperones with appropriate training.

Ensure all staff should receive personal development and support.

Record all discussions and actions to be taken from practice meetings.

Dr Bose & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Dr Bose & Partner

Dr Bose and Partner is located on the first floor of the Tunstall Primary Care Centre, a purpose built, primary care medical centre located in Tunstall, Stoke on Trent. Dr Bose and Partner serves the local population by providing general medical services.

The practice has two permanent GPs (both male), a practice manager, a practice nurses, and three reception / administration staff. There are 2189 patients registered with the practice. The practice is open from 8.30am to 7pm Monday and Tuesday, 8.30am to 6.30pm Wednesday and Friday, and 8am to 1pm on Thursday. The practice offers extended hours on Monday, Tuesday and Wednesday evenings. Patients can access the service for routine appointments from 9am to 11.30am every weekday morning, and from 4.30pm to 6.50pm on Monday and Tuesday, 4.30pm to 6.20pm on Wednesday and 3pm to 5pm on Friday. The practice is also providing emergency appointments on Saturday mornings from 8.30am to 12.30pm until February 2015, as part of an initiative to reduce accident and emergency admissions during the winter period.

The practice provides a number of clinics for example long term condition management including asthma, diabetes and high blood pressure. It offers child immunisations, minor surgery and travel health.

Dr Bose and Partner has a General Medical Services contract.

Dr Bose and Partner does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

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

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

Detailed findings

We carried out an announced visit on 3 December 2014. During our inspection we spoke with two GPs, one practice nurse, the practice manager, and three reception/ administration staff. We spoke with six patients who used the service about their experiences of the care they received. We reviewed 16 patient comment cards sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group.

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)

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. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. 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 15 months and we were able to review these. Significant events was a standing item on the practice meeting. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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. The practice manager showed us the system she used to manage and monitor incidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we found there had been a prescribing error where an item had been overprescribed each month. This had arisen from a typing error, and all staff were advised to be vigilant when creating repeat prescriptions. We saw that incidents were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust. Staff told us incidents were discussed at the locality meetings, and provided shared learning for the practices across the locality.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with described the action they would take for alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review the risks to vulnerable children, young people and adults. All staff had received training in safeguarding vulnerable adults and children, and this was supported by the training records. Staff we spoke with confirmed they had completed safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

Both GP partners acted as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. 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.

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, children in need and patients who were also carers. The practice also maintained registers for children in need, on protection plans and looked after children (in the care of the local authority)

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurse acted as a chaperone for the doctors when on duty. However, reception staff fulfilled this role when the practice nurse was not available. Although the reception staff had not received formal training, they understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice manger told us the local Clinical Commissioning

Good

Are services safe?

Group was organising chaperoning training for practice staff. Patients spoken with told us they were always offered a chaperone by the GPs when carrying out any examinations.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS Web, which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us they had a very good working relationship with the health visitor attached to the practice. Although they did not meet on a regular basis, the health visitors were located in the same building. This provided the opportunity to discuss any concerns as they arose, for example, a child not attending for their immunisations. Staff told us the health visitors reviewed all newly registered children under the age of five, to ensure that relevant information was shared appropriately.

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. A log of the fridge's temperature ranges had been recorded daily. This demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in the policy.

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 there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Any changes to medicines requested by either the hospital or the patient were reviewed by the GPs before the prescription was issued.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Systems were in place to record the name of the person who collected the prescription from the practice, including pharmacies which offered a collection service. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by the Medicines Management Team from the local Clinical Commissioning Group. A member of the team visited every two weeks and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. The needs of identified patients were reviewed by the GPs prior to any decisions being made regarding any changes.

Cleanliness and infection control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy. Comments made on the comment cards completed by patients also supported this. We saw that the practice was clean and orderly. We saw there were cleaning schedules in place and cleaning records were kept.

All staff had undertaken infection control training, and the practice nurse was the infection control lead. An infection control audit had been carried out in November 2014 and action had been taken to address the issues identified. For example, displaying hand washing posters above sinks and providing bodily fluid spillage kits within the practice. The audit had identified that the chairs were fabric covered and

the practice was seeking advice from the landlord regarding arrangements in place for cleaning these chairs. The practice nurse told us they needed to start recording when infection control issues were discussed at practice meetings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal disposable equipment including disposable gloves, aprons and coverings were available for staff to use. Staff confirmed they used single use equipment for procedures.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received the appropriate immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries, which staff were aware of. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The landlord of the building had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella assessment had been completed in March 2014. The caretaker employed by the landlord was responsible for carrying out regular checks in line with this policy in order 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 weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. Most staff had worked at the practice for many years. We looked in the file of one member of staff who had recently been recruited. We saw that the appropriate checks had been carried out

Checks through the Disclosure and Barring Service (DBS) had been completed for the GPs who worked at the practice, and staff who had been employed recently. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults and children. Risk assessments were in place for reception staff without DBS checks. However, the practice nurse did not have a DBS check or risk assessment in place. The practice manager assured us that a DBS check would be requested for the practice nurse following our inspection.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The staff team consisted of two GPs (9 sessions a week), one practice nurse (20 hours a week), the practice manager, and three reception / administration staff. Arrangements were in place to cover the annual leave of GPs and reception staff. There were no arrangements in place to cover the practice nurse's annual leave. The practice manager told us that clinics were not held when the practice nurse was on leave.

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 weekly fire alarm checks, medicines management, and dealing with emergencies and equipment. The practice also had a health and safety policy. Staff told us they could access the policies and procedures on the practice's intranet and paper copies were also available.

Identified risks were included on a risk log. The practice manager told us that the risk assessments and policies were reviewed on an annual basis. We saw that any risks were discussed at the practice meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

Good

Are services safe?

and well-being. The practice had identified their most vulnerable patients and developed individual care plans for each patient. The aim of this was to reduce the number of unplanned admissions to hospital.

The practice worked closely with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers. A member of reception staff described the action they had taken when they were concerned about a patient's condition. They told us during a telephone call with a patient they became concerned about the patient's breathing. They transferred the call to the GP, who arranged for an emergency ambulance to visit the patient.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us they received training in basic life support, and training records supported this. Emergency equipment was available that included access to oxygen but not to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The practice held a limited range of medicines to deal with emergencies. These included those for the treatment of cardiac arrest and anaphylactic shock. The practice did not have medicines to treat low blood sugar, although they had recognised the need to stock this medicine. Staff told us they would dial 999 and call an ambulance in the event of an emergency. A full risk assessment had not been undertaken to determine which medicines and equipment the practice needed to stock. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, major disruption including loss of staff and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utilities company if any utility failed. The practice manager told us arrangements were in place to use the branch practice of the GP practice located in the same building if they were unable to access the building. The practice manager told us that although the business continuity plan was available in the building, no copies were held off site.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff told us that new guidelines, 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. Staff told us they attended training provided by the local Clinical Commissioning Group which discussed changes to guidelines on diabetes. We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

One of the GPs took the lead role and supported the practice nurse with the care of patients with long term conditions and chronic disease management. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 98 QOF points out a possible 100, which was higher than the national average. For example, we saw that the percentage of patients aged 75 years and over with a fragility fracture who were receiving the appropriate medication was above the national average. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice did not fall outside the normal range for any QOF (or other national) clinical targets. The practice had also signed up to the local Clinical Commissioning Group Quality Improvement Framework (QIF). The QIF is underpinned by a learning and development programme, with workshops and best practice documents. The senior GP partner showed us data from the QIF of the practice's performance for prescribing. We saw that this was lower than the CCG average and demonstrated that the practice was proactive in monitoring the prescribing of medicines.

The practice showed us two clinical audits undertaken in the last two years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example: the practice carried out an audit of patients with chronic obstructive pulmonary disease (COPD / lung disease). The purpose of the audit was to ensure that spirometry was being interpreted in the diagnosis of COPD, and that clinical management matched best practice. The results showed that patients were correctly diagnosed and the practice had achieved the results required by COPD Best Practice in Clinical Management. Other examples included audits to check if the practice was delivering consistently good quality care for patients with confirmed or suspected chronic kidney disease.

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 practice was supported by the medicines management team from the local Clinical Commissioning Group, who flagged up relevant medicines alerts and identified patients on this medicine. We were told that, after receiving an alert, the GPs 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 practice had achieved and implemented the gold standard framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses such as basic life support and safeguarding vulnerable adults and children. All GPs were up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. However, the practice nurse told us they had not had an appraisal for over two years. The practice nurse had defined duties they were expected to perform and was able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

Blood results, X-ray results, letters from the local hospital including discharge summaries, information from out of hours providers and the 111 service were received either electronically or as a paper copy. Information from other services about patients was reviewed each day by whichever GP was working. Each GP was responsible for the action required and would either record the action or arrange for the patient to be contacted and seen as clinically necessary. The practice used an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician. Required actions were recorded on the electronic system and passed on to the relevant person to action.

A number of other services were also located in the same building as the practice, for example, community nursing staff including district nurses, health visitors and palliative care nurses. The practice staff told us this improved communication as they were able to discuss any concerns about patients with the community staff as they were located in the building. They told us any informal discussions were recorded in the patient's notes.

The practice held multidisciplinary team meetings to discuss patients on the palliative care register. These meetings were attended by district nurses, palliative care nurses, the GPs, practice nurses and health care assistants. All patients identified as having end of life needs were discussed 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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice made 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).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMISWeb to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Information from other services about patients was reviewed on the day it was received.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, assessment of Gillick competence of children and young adults, and information around the Fraser guidelines. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. We found there was a lack of clarity around appointments for unaccompanied children. We were told that appointments weren't refused but the child was encouraged to bring a parent to the appointment.

The GPs spoken with told us they had received training on the Mental Capacity Act and assessing patients' mental capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. The practice nurse told us if they had any concerns about a person's capacity to make

Good

Are services effective?

(for example, treatment is effective)

decisions, they would ask a GP to carry out an assessment. They told us that patients had a choice about whether they wish to have a procedure carried out or not. They told us they took the time to fully explain procedures and checked the patient understood before proceeding. The practice manager told us that all staff had received some form of training on the Mental Capacity Act 2005 although this was not reflected in the training records.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. They used the data from QIF and QOF to help to identify these needs.

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history. It was practice policy to carry out a new patient health check on all under five year olds and patients over the age of 16. Children between the ages of five and 16 were invited for health check based on the information in the questionnaire.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, referral to the Healthy Lifestyle programme and local quit smoking programme. We were also told that the practice carried out child immunisations and offered family planning advice and support. The practice nurse told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They had a range of leaflets available to give to patients, and leaflets were also available in the waiting room.

The practice referred patients who had been newly diagnosed with diabetes to a diabetes management programme. This provided patients with guidance on lifestyle, diet and medication. Patient with chronic obstructive pulmonary disease (lung disease) were referred to the pulmonary rehabilitation programme.

Flu vaccination was offered to all over the age of 65, those in at risk groups, pregnant women and children between the ages of two and four. The percentage of eligible patients receiving the flu vaccination was above the national average. The shingles vaccine was offered according to the national guidance for older people.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with or above the average for the local clinical commissioning group.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 50 patients undertaken by the practice's patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from both these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The survey showed that 82% patients felt that the last GP they saw or spoke with was good a treating them with care and concern, which was above the Clinical Commissioning Group (CCG) area average. 89% of the patients who responded said that they had confidence and trust in the nurse they had seen last at the practice, which is above the Clinical Commissioning Group (CCG) area average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards which were very positive about the service experienced. Patients said they felt the practice offered an excellent service, and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. One comment made was that all the staff worked as a team. We also spoke with six 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Throughout the inspection we saw and heard staff speaking with patients in a helpful and respectful manner. We asked patients about confidentiality and no one expressed any concerns. A notice about confidentiality was on display on the reception desk, and a privacy booth was available for patient use. 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. The seated waiting area was away from the reception desk, preventing conversations from being overheard.

Staff told us that the practice cared for patients whose circumstances may make them vulnerable. This included children who were looked after by the local authority, people who lived on nearby narrow boats (who are classed as having no fixed abode), asylum seekers and people with mental health needs. The GPs told us they had visited a patient at home who had mental health needs as they had been unable to contact them by telephone to arrange their annual review. They told us this had improved the contact between the patient and the practice. Staff told us that these patients were supported to register as either permanent or temporary patients, as the practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

There was information on the practice's website stating the practice's zero tolerance for abusive behaviour. We saw that this policy had been used twice during 2014; one patient had received a letter about their behaviour and future conduct, and another patient had been informed that their registration was being removed.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. One patient told us the GPs explained all the options available to them, as well as any side effects or risks. This enabled the patient to make an informed decision about the choice of treatment they wished to receive. Patient comments on the comment cards we received were also positive and supported these

Good

Are services caring?

views. One patient commented that when they accompanied their child during an appointment, the GP focused their attention and questions towards the child and not the parent.

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. They generally rated the practice well in these areas. For example, data from the national patient survey showed that the practice was above the CCG area average with 76% of practice respondents saying they felt the GP involved them in care decisions and 81% said the same for the nurse. However, the number of who said the GP (81%) was good at explaining treatment and results was below the CCG area average.

Staff told us that the population of the patients at the practice were mainly white, British people, although the number of patients from ethnic minority registered with the practice was increasing. Staff told us that support for people whose first language was not English tended to come from their own family although an interpreter service was available.

The practice had taken on the enhanced service for the avoidance of unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. To meet this objective they had identified 51 patients who were assessed as the most vulnerable. Each patient was offered the opportunity to develop an individual care plan, although a number of patients had declined. Every patient over 75 years of age had a named GP. The practice had eight patients on their palliative care register. We saw that multi-disciplinary meetings between GPs, palliative care nurses and district nurses were held every eight weeks to review care plans for patients near the end of their life. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

There were 19 patients on the practice's learning difficulties register. Staff told us that annual health reviews were carried out for patients with learning difficulties and care plans developed following the review. There were 18 patients on the practices' register for patients with mental health difficulties. There was a system in place to ensure that patients with mental health difficulties received an annual health review. The practice held a register of patients with long term conditions which included patients with coronary heart disease; diabetes; chronic obstructive pulmonary disease and asthma. We saw that there was a system in place that ensured patients received an annual health review. The practice nurse told us that appointment days and times for patients with long term conditions were flexible to accommodate patients' preferences. The Quality and Outcomes Framework (QOF) data that we reviewed showed that the percentage of patients diagnosed with dementia who had received a review of their care in the previous 15 months was in line with national standards.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 82% of patients surveyed said the last GP they saw or spoke with was good at treating them with care and concern with a score of 83% for nurses. Both of these results were above the CCG area average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as excellent.

Notices in the patient waiting room and patient website told people how to access a number of support groups and organisations. Information leaflets were also available in the practice. The practice's computer system alerted GPs if a patient was also a carer.

Patients nearing the end of their life had their care and support reviewed at bi-monthly multidisciplinary meetings which included practice staff, district and palliative care nurses. Staff told us that if families had suffered a bereavement, the practice always send a condolence card signed by all of staff. Staff also said that patients could be referred to Dove, a local bereavement counselling service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, the practice offered extended hours in an evening, as these were more popular with patients than early morning.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. The practice was monitoring the risk of unplanned admissions and had developed individual care plans for patients. We saw that longer appointments were available if required. The practice was also part of a pilot reviewing Accident and Emergency admissions on a weekly basis. Any inappropriate admissions or patients who could be seen by the GPs were identified and contacted. This had identified several patients who thought they had to visit A/E to receive certain medication. These patients were now visiting the practice to receive the same medication, reducing their admissions to A&E.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had signed up to CCG Quality Improvement Framework (QIF). The QIF shows how improvements have been made across the area, for example in the in the area of blood pressure control.

The GP partners attended the local Clinical Commissioning Group meetings, and told us that these meetings provided effective two way communication. The GP partners and practice manager also attended the locality meetings, which provided the practice with an opportunity to discuss any issues, for example: specific cases and A&E admission rates.

The practice had an active Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. This was a joint PPG with another GP practice located in the same building. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group recognised there wasn't a good distribution of patients from different age groups. They were trying to address this through information in the practice, on the practice website and through the annual survey. There was evidence of meetings with the PPG every two to three months throughout the year. The representative told us the PPG had a good working relationship with the practice, and the practice supported them information sharing. For example, the PPG obtained health promotion leaflets and posters which the practice made available to patients.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff told us the practice cared for looked after children (in the care of the local authority), people who lived on nearby narrow boats (who are classed as having no fixed abode), and asylum seekers, as well as patients with learning disabilities, mental health needs and dementia. Staff told us that these patients were supported to register as either permanent or temporary patients. They told us all patients received the same quality of service from all staff to ensure their needs were met.

The majority of the practice population were English speaking patients though the practice could cater for patients who used other different languages through translation services. The practice had access to telephone translation services. There were no female GPs at the practice, which limited the options for patients who preferred to have a female doctor. We saw that several patients had commented on the need for a female GP at the practice. The practice manager told us that female patients who expressed a preference to be seen by female were identified on the electronic note system. The practice nurse was always present acting as a chaperone for all GP appointments for these patients.

The practice provided equality and diversity training through e-learning. Training records showed this training was overdue for one member of staff, and the newly recruited member of staff needed to complete this training.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the first floor of the building. There was a lift to the first floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation

Good

Are services responsive to people's needs?

(for example, to feedback?)

rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Facilities for patients with mobility difficulties included disabled parking spaces; electronic entrance doors to the practice; disabled toilets and a hearing loop for patients with a hearing impairment.

The practice provided care and support to several house bound older patients and patients living in two local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. GPs provided home visits and visited the housebound patients to provide home 'flu vaccinations to reduce the risk of seasonal infections. The GPs took the opportunity to review housebound patients at this home. However, the practice planned to take a more proactive approach and maintain a register of housebound patients and review their needs on a more regular basis. Patients with learning disabilities were provided with annual health reviews at the practice.

Access to the service

The practice booklet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. 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, the call was automatically diverted to the out-of-hours service.

The practice opened from 8.30am to 7pm Monday and Tuesday, 8.30am to 6.30pm Wednesday and Friday, and 8am to 1pm on Thursday. The practice offered extended hours on Monday, Tuesday and Wednesday evenings. Patients could access the service for routine appointments from 9am to 11.30am every weekday morning, and from 4.30pm to 6.50pm on Monday and Tuesday, 4.30pm to 6.20pm on Wednesday and 3pm to 5pm on Friday. This supported working age patients and children and young people to access appointments outside of normal working hours. The practice was also providing emergency appointments on Saturday mornings from 8.30am to 12.30pm until February 2015, as part of an initiative to reduce A&E admissions during the winter period.

Patients were 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. Comments received from patients showed that patients in urgent need of treatment were offered same day appointments. Non urgent appointments were usually provided within two working days of contacting the practice, although appointments could be booked up to two weeks in advance. We saw that appointments were available during the week of our inspection. Data from the national GP survey supported this. 95% of respondents stated they were able to get an appointment last time they tried and 96% described their experience of making an appointment as good. These were above the regional CCG average.

We saw evidence that there was partnership working with other agencies to understand the needs of the most vulnerable in the practice population. This included working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers, to provided coordinated care for patients nearing the end of their life.

The practice kept a register of patients who were experiencing poor mental health to monitor and inform service provision. Patients were invited for an annual health reviews carried out by the GPs. The practice also worked closely with MIND, Healthy Minds and Child and Adolescent Mental Health Services (CAMHs) to provide support for adults and children experiencing poor mental health.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was a notice displayed on the reception desk, information in the practice booklet and on the website. None of the patients we spoke with had ever needed to make a complaint about the practice. One patient told us they had informed the reception staff that they were unhappy about the attitude and help from a health care professional linked to the practice but employed by the local NHS trust. The reception staff dealt with these concerns efficiently and

Good

Are services responsive to people's needs?

(for example, to feedback?)

passed the information on to the relevant NHS trust, who responded to the patient in a timely manner. Reception staff spoken with clearly described the action they would take if a patient wished to make a complaint.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled and responded to in a timely way.

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 consistent, personalised care based on the traditional model of general practice. The practice philosophy was outlined in the Practice Charter, which was available to patients. The charter had been revised in September 2014. The philosophy included to offer the highest standard of health care and advice to patients, with the resources available; to have a team approach to patient care; to monitor the service provided to patients to ensure it meets current standards of excellence, and is dedicated to ensuring the staff and doctors are trained to the highest level. It was clear when speaking with the GPs and the practice staff they shared this vision and were committed to providing personalised care. Patients commented they felt they received personalised care and staff knew them by their name. We observed this in waiting room, when the receptionist referred to the patient by their first name, without having to ask who they were.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet, or as paper copies. The practice manager told us the plan was to review all polices annually. They were aware that the reviews were overdue. We saw that staff had completed a cover sheet to confirm that they had read the policy and when.

There was a clear leadership structure with named members of staff in lead roles. For example, the practice nurse was the lead nurse for infection control and one of the GP partners was the lead for safeguarding. All staff spoken with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing above national standards by obtaining 98 QOF points out a possible 100. The practice had also signed up to the local Clinical Commissioning Group Quality Improvement Framework (QIF). The QIF is underpinned by a learning and development programme, which workshops and best practice documents.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example: infection control, chronic kidney disease and chronic obstructive pulmonary disease. Findings were shared with staff and actions and recommendations were recorded.

The practice had arrangements for identifying, recording and managing risks. The building in which the practice was located was owned by a private landlord, who was responsible for the risk assessments relating to the building. The building administrator showed us their risk assessments for potential issues, such as Control of Substances Hazardous to Health (COSHH), fire safety, buildings and prevention of the legionella virus. The practice manager had carried out risk assessments specific to the area of the building they occupied. As a result they had identified that the panic alarms in consulting and treatment rooms only sounded in the main building reception and not in the practice reception. As a consequence, they had purchased wireless alarms that sounded in practice reception, until the situation could be resolved with the landlord.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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.

We saw from minutes that three practice meetings had been held during 2014. These meetings were used to discuss a range of topics, including complaints and significant events. The GPs and practice nurse told us they discussed clinical issues on a regular basis but these meetings were informal and minutes were not recorded to enable reference to over time. 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 practice was part of a pilot within the local CCG working towards completing 'Productive General Practice'.

Are services well-led?

Good

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

This programme was designed to help general practices continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations. The GPs told us this programme would help the practice to further develop and meet the demands in the future.

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

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

The practice had gathered feedback from patients through patient surveys and complaints. The practice was working with the Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The 2013 / 2014 patient survey focused on receptionists, appointments, consultations and keeping healthy. The survey did not highlight any issues from patients about the service they received. The PPG had identified they would like to improve the provision of health information leaflets and posters, but recognised that space was limited. They also recognised that the group was struggling to attract new members. An action plan had been developed and included plans to make the survey available electronically in the future, and to form a virtual PPG via the practice website.

The practice had joint Patient Participation Group (PPG), with the GP practice located in the same building, as well as a virtual PPG group. The survey results and action plan were available on the website, although the minutes of the meeting were not. The PPG met every two to three months. They told us that either the practice managers and /or the GPs attended the meetings whenever possible. Results of patients' surveys and PPG comments were shared with patients through the practice website. We saw that the PPG had developed an action plan and the practice had worked with the PPG to carry out the issues within the action plan. The chair person for the PPG confirmed that they had a very good working relationship with the practice and that the GPs and practice managers were open and honest and listened to what they said.

The practice gathered feedback from staff 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. 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 electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The practice nurse told us they could request to request training that was relevant to the needs of the practice population and the practice supported this. However, the practice nurse told us they had not had an appraisal for over two years. We looked at two reception / administration staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was able to evidence through discussion with the GPs and practice manager and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant events received and investigated had been discussed at the whole practice meeting held on 1 October 2014. We saw the practice significant events log for 2014 which gave details of the incident, who was involved, action taken and lessons learned. We saw that SE's were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust. Staff told us incidents were discussed at the locality meetings, and provided shared learning for the practices across the locality.

Both GP partners held external and strategic roles with other health agencies. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. For example, one GP was locality lead for prescribing sat on the local Drug Implementation committee. As a consequence the practice had lower prescribing costs than other practices in the locality. The other GP was the CCG cancer lead, and also involved in the appraisal of GPs as part of their revalidation

Are services well-led?

Good

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

process. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.