Drs Healy, Thornett and Sherringham

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?	Requires improvement
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

Drs Healy, Thornett and Sherringham (also known as Stow Surgery) is a semi-rural dispensing practice providing primary care services to patients resident in Stow-on-the-Wold and the surrounding villages from Monday to Friday. The practice has a patient population of 5,500 of which 28% are over 65 years of age. The practice supports training for medical students and doctors specialising in general medical practice. It is also a practice which participates in medical research.

We undertook a scheduled, announced inspection on 4 November 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC pharmacy inspector.

The overall rating for the practice is GOOD

Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in their treatment decisions.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice had met the requirements of the Gold Standards Framework for the care and support of patients at end of life and their families. Patients were supported to complete advance care planning documentation to record their end of life treatment decisions.
- Patients were treated by suitably qualified staff.
- GPs and nurses followed national guidance in the care and treatment provided.
- The practice worked closely with the community to meet the specific needs of the patient population for example, co-ordinating patient appointments with the bus timetable and the delivery of patient medicines to outlying villages.

Summary of findings

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

The provider **should:**

- Undertake a risk assessment and develop and update standard operating procedures for the storage, dispensing and administration of medicines such as patient group directions and liquid nitrogen.
- Ensure there are reasonable updates to the décor and repairs to the building based on a risk assessment whilst, planning permission for a new and updated building is agreed and the new building is finished.
- Improve systems to monitor the cleanliness of the building.
- Ensure reasonable updates to the building and facilities are updated to improve access for patients with mobility needs whilst planning permission for a new and updated building is agreed and the new building finished.
- Develop a schedule of regular clinical audit cycles to demonstrate organisational learning and change to patient care as a result.
- Improve staff information about alternative agencies to contact when there are concerns about patients at risk of abuse.
- Improve systems to audit minor surgery undertaken in the practice including the follow up of patient test results.

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?

Requires improvement

The practice is rated as requires improvement for safe as there were areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong, lessons learnt were not communicated widely enough to support improvement and actions were not consistently addressed for example, the storage of medicines in GPs bags. Most risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the décor and fabric of the building required updating and repair to aid cleaning and reduce the risk of infection. The practice did not have all the procedures in place to support the safe storage, dispensing and administration of medicines such as patient group directives and medical gases.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Social Care Excellence 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 essential training such as basic life support appropriate to their roles. The practice could identify all appraisals and the personal development plans for all staff. However, further training to enable continuing professional development for some staff was not supported by the practice.

Are services caring?

Good

The practice is rated as good for caring. Data from the GP National Patient Survey 2014 showed patients rated the practice higher than others for several aspects of care. Patients told us 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 staff communicated with patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. Overall the practice had good facilities and was well equipped to treat patients and

Summary of findings

meet their needs. There was a complaints system however, the complaints process was not visible in the practice or readily accessible to patients without asking staff. Evidence demonstrated the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice worked closely with the community to meet the specific needs of the patient population. For example co-ordinating patient appointments with the bus timetable. The delivery of patient medicines to outlying villages during periods of severe weather e.g. snow.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and overall staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data from the Quality and Outcomes Framework (QOF is a national performance measurement tool) showed the practice had good outcomes for conditions commonly found amongst older patients.

The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care.

The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

The practice worked closely with the local community to enable patient access to primary care services. The practice had advertised for a nurse to support and minimise admission to hospital for the most vulnerable older patients.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Emergency processes were in place and prompt referrals made for patients in this group who had a sudden deterioration in health.

When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check that their health and medication needs were being met.

For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had in place advance care planning to support patients with long term conditions with respect to their end of life choices and decisions.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, the GP met regularly with health visitors to review children and their families at risk.

Immunisation rates were relatively high for all standard childhood immunisations.

Summary of findings

Patients told us and we saw evidence to demonstrate that children and young people were treated in an age appropriate way and recognised as individuals.

Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses.

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 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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities. The practice offered longer appointments for patients requiring more time with their GP with learning disabilities. The practice held a register of patients living in 'tied' accommodation due to the prevalence of farming as an occupation and an ageing population in this area of work. .

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector 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 who to contact within the practice. However, staff told us that they were not confident in contacting other relevant agencies such as social services if the safeguarding lead was not available.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia. The practice

Summary of findings

had initiated care plans for patients experiencing poor mental health. Quality data from QOF demonstrated the practice compared favourably with other practices in the diagnosis and assessment of depression.

The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions.

The practice website included useful links to other information and support services. The practice had in place advance care planning to support patients with dementia in order to respect their end of life choices and decisions.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with seven patients attending the practice and a representative from the patient participation group. We looked at 27 patient comment cards, feedback from a practice patient survey (2013), the NHS Choices website and the GP National Patient Survey 2014.

Patients we spoke with were highly satisfied with the care and treatment received. They appreciated staffs' friendly, caring and empathetic approach. Patients gave examples of care from the GPs who were valued because they were patient, good listeners and knowledgeable of their needs. This was supported by feedback from the GP National Patient Survey 2014 which indicated 98% of the practice' respondents found the receptionists helpful and 96% described their experience of the practice as good or very good. Patients felt their privacy and dignity were respected by staff.

All of the patient feedback told us patients were able to get an appointment. However, three patients told us their appointment time often ran late. It was acknowledged by patients this was because the GPs were thorough and spent time with them and they did not see this as a complaint. The GP National Patient Survey confirmed 40% of patients had said they waited more than15 minutes for their appointment. Patients we spoke with were not aware of the complaints process. They expressed confidence in the practice's management of concerns they might raise.

Patients were included in their care decisions, were able to ask questions of all staff and had their treatment explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2014 which indicated 85% of patients said their GP was good at explaining tests and treatment.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider **should:**

- Undertake a risk assessment and develop and update standard operating procedures for the storage, dispensing and administration of medicines such as patient group directions and the use of liquid nitrogen.
- Ensure there are reasonable updates to the décor and repairs to the building based on a risk assessment whilst, planning permission for a new and updated building is agreed and the new building is finished.
- Improve systems to monitor the cleanliness of the building.
- Ensure reasonable updates to the building and facilities are updated to improve access for patients with mobility needs whilst planning permission for a new and updated building is agreed and the new building finished.
- Develop a schedule of regular clinical audit cycles to demonstrate organisational learning and change to patient care as a result.
- Improve staff information about alternative agencies to contact when there are concerns about patients at risk of abuse.
- Improve systems to audit minor surgery undertaken in the practice including the follow up of patient test results.

Drs Healy, Thornett and Sherringham

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC pharmacy inspector.

Background to Drs Healy, Thornett and Sherringham

Stow Surgery is a small semi-rural dispensing practice providing primary care services to patients resident in Stow–on-the-Wold and surrounding villages. The practice has a planning application in process to build a larger purpose built GP facility in the town.

Most patient services are located on the ground floor of the building. The practice has a patient population of approximately 5,550 patients of which 28% are over 65 years of age.

The practice has two male and one female GP partners. Full time partners work nine sessions per week whilst part time partners work five or six and a half sessions.

They employ a practice manager, four nursing staff, nine administrative staff and two dispensing staff.

Each GP has a specialist lead role within the practice and nursing staff have specialist interests to aid their understanding of patient need within areas such as respiratory disease and diabetes.

Primary care services are provided by the practice Monday to Friday during working hours (8am-6.30pm). In addition early morning and later evening appointments are available one day a week. GPs are available for telephone advice and home visits. The practice has opted out of the out of hour's primary care provision. This is provided by another out of hour's provider. Patients are informed of this provision via the surgery telephone number which automatically diverts the call, the practice website and the practice patient booklet.

Why we carried out this inspection

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

This practice had not been inspected before and that was why we included them.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before our inspection, we reviewed a range of information we held about the service and asked other organisations, such as the Gloucestershire Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 4 November 2014. During the inspection we spoke with four GPs, the practice manager, four nursing staff, administration and dispensing staff. We spoke with seven patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at practice documents such as policies, patient care plans and pathways, clinical audit and significant event reviews, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with was aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we saw the theft of a GP's medical bag in the summer of 2014 had been reported and appropriate action taken in response to minimise risks.

We reviewed adverse events and incident reports from the July 2013 to October 2014 and January 2014 respectively.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 18 months. A slot to discuss significant events was on the quarterly clinical meeting agenda and to review actions from past significant events and complaints. There was evidence learning had taken place as there had been changes to practice. We noted the changes had yet to be evaluated to monitor their effectiveness. We saw from meeting minutes that not all of the relevant staff had been included in the reviews. However, staff including receptionists, administrators and nursing staff told us they were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incidents

National patient safety alerts were disseminated by email to practice staff and discussed at staff meetings. This ensured all staff were aware of those relevant to their practice and where action needed to be taken. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for such as the use of specific diagnostic test strips for testing for a range of constituents in urine.

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 showed that one member of staff had not received relevant role specific training about safeguarding children. The member of staff had recently joined the practice. Arrangements were in place for training to be updated. All GPs had undertaken level three safeguarding children training in line with national guidance. We noted only two members of staff had completed safeguarding vulnerable adults training. Medical, nursing and administrative staff we spoke with explained how they recognised signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing within the practice and the documentation of safeguarding. However, not all staff we spoke with were confident about the relevant external agencies to contact in and out of hours. The practice safeguarding policy included a link to the local authority safeguarding website and a shortcut to the same link was on the practice desktop. The policy did not include telephone numbers or contact details of other agencies such as the Care Quality Commission or the police.

The practice had dedicated GP's with lead responsibilities for safeguarding vulnerable adults and children who had been trained 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 raise staff awareness of relevant issues when patients attended appointments. For example, children subject to child protection plans. We saw from clinical meeting records patients who were deemed to be at risk were discussed with the relevant healthcare professionals involved in their support to ensure continuity and ongoing communication.

The practice had a chaperone policy. Signs were in place to remind patients they could ask for a chaperone. These were visible on the waiting room noticeboard and in consulting rooms. Staff were aware of their roles and responsibilities regarding chaperoning. If nursing staff were not available to act as a chaperone, there were some administrative staff who had been orientated to the role and had undergone criminal records checks via the Disclosure and Barring Service to verify their appropriateness to undertake the role.

Patient's individual records were written and managed in a way which helped ensure their safety. Records were kept on an electronic system. On the day of the inspection the

practice had started transferring to a different electronic records system. Staff explained the process which enabled communications about the patient including scanned copies of communications from hospitals to be checked and transferred to the patient record. We noted that the system which followed up on patients test results following minor operations undertaken at the practice was not regularly completed.

There was a system to review repeat medicines for patients with co-morbidities and multiple medicines. We were told changes to patient's medicines by other healthcare providers were addressed by the GPs or practice nurse and the healthcare provider was contacted if a discharge summary had not been received. There was an alert on the electronic records to ensure patients received an annual medicines check.

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 policy which ensured medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked including medicines for use in an emergency were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Practice staff had a system to monitor the stock and expiry dates of medicines kept in the GP's bags. However, some of the recommendations which resulted from a recent significant event review regarding the storage of medicines held in GPs bags had not been followed. This concerned the appropriate storage to maintain the optimum temperature of medicines and could result in a risk of medicines being less effective if administered to patients.

We saw records that noted the actions taken in response to a review of prescribing data. For example, a review of patients taking anti-inflammatory medicines with blood thinning medicines demonstrated patients had been appropriately prescribed anti-inflammatory gel rather than tablet form.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure patient's repeat prescriptions were still appropriate and necessary.

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures which set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard. Keys were held securely and only accessible to nominated staff. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We observed this process was working in practice.

We saw records which showed all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

We found the directions for the administration of vaccines by nurses were not consistently completed in line with legal requirements and national guidance. For example, the appropriate person to authorise staff to use the patient group direction. (Patient Group Directions (PGDs) are documents permitting the supply of prescription-only medicines (POMs) to groups of patients, without individual prescriptions. Healthcare workers using PGDs should be sufficiently trained to be able to supply and administer POMs). The practice did not have a procedure or information regarding directions for the administration of vaccines as a patient group direction as guidance for staff.

Requires improvement

Are services safe?

We saw evidence nurses were up to date with training to administer vaccines.

The storage of liquid nitrogen for the use of cryosurgery (the destruction of tissue by application of extreme cold; for example, wart removal) had not been risk assessed. The storage vessel was kept in the staff toilet. Warning signs were not displayed on the door to inform staff or patients of the risks. We were told by the practice manager there was a procedure regarding the management and use of liquid nitrogen as guidance for staff.

Cleanliness and infection control

We saw 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. However, we saw in the treatment room where minor operations took place, there was dust on the window blinds and the skylight was dirty. The taps at the hand washing sink were badly lime scaled. The floor seams were not intact and edging to some of the skirting was damaged. We noted in consultation rooms carpets were stained. There was carpet in a clinical area used for taking blood and other minor clinical procedures. Failure to maintain and clean the appropriate surfaces allowed dust and debris to accumulate and could have presented a risk of cross infection.

The practice had a lead for infection control. We saw evidence the lead had carried out an infection control audit in 2014. There were some areas of improvement identified from the audit. An action plan which identified when the improvements would be completed and who was responsible for ensuring the work was done had not been produced.

We saw from training records three of the four nursing staff had received infection control training within the last year. Other staff had not received infection control training. There was an infection control policy and supporting procedures were available for staff to refer to. These enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy for example, wearing gloves when handling specimens. There was also a policy for needle stick injury. Injury. (A needle stick injury is a percutaneous piercing wound typically set by a needle point, but possibly also by other sharp instruments or objects).

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However, hand washing sinks in clinical areas had plugs which was not in line with national guidance.

The practice manager undertook monthly spot checks of the premises which ensured the practice was clean and the contractors had fulfilled their obligations. We saw records that demonstrated environmental cleaning issues were reported to the contractors to address.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs and other records that confirmed equipment was regularly tested. 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

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy which 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 the different staffing groups which ensured there were enough staff 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. Newly appointed staff had this expectation written in their contracts.

Requires improvement

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

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 regular checks of the building, the environment, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We were told any risks were discussed with relevant members of staff.

Patients gave us examples of how their GP responded to deterioration in their condition. For example, contacting the hospital when they were concerned about changes in a patient's condition which required prompt attention. Nursing staff told us if they were concerned about a change in a patient's condition they would seek advice from the GP, or make an appointment for the patient to see the GP. For example, if a patient had a raised blood sugar or changes in their usual baseline observations (breathing rate, blood pressure).

We saw from Quality and Outcome Framework (QOF) data monitored the effects of certain medicines. For example all patients experiencing poor mental health prescribed lithium had a blood test to identify any side effects. All eligible patients experiencing poor mental health had a cervical smear as part of the practice health screening programme.

Patients with long term conditions attended the practice nurse for regular screening. The practice offered anti coagulation screening to determine whether patients' blood clotting times were within normal limits. Nurses held appointments to monitor patients' with long term condition and responses to medicines. The frequency of appointments was made on assessment of risk and patient preference. QOF data 2013/2014 demonstrated patients with long term conditions had annual reviews. The practice worked with members of the multi-disciplinary team to support patients at end of life. This included working with other health care providers to enable anticipatory prescribing to manage foreseeable symptoms such as pain. The practice used an advance care planning tool with patients to enable to manage any change in the patient's condition to be managed in accordance with their wishes.

Staff were trained to identify children at risk and their families. Staff recognised the signs and symptoms of abuse and knew how to report child protection concerns to the safeguarding lead in the practice.

Women were able to attend the well women clinic at the practice for breast examination and cervical smear tests.

Older patients were supported to attend the practice for appointments and screening for long term conditions by arranging appointments around village bus services. The practice met with members of the multidisciplinary team to identify and develop care plans for patients assessed as being at risk of unplanned hospital admission. The practice had advertised for a nurse to support and minimise admission to hospital for the most vulnerable older patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and two automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient who had collapsed had been discussed. The records demonstrated the practice had successfully followed life support procedures prior to patient transfer to hospital. We saw points for improvement had been addressed in a timely manner.

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 available in the practice that 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

Requires improvement

Are services safe?

the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained the contact details of main services for staff to refer to.

A fire risk assessment had been undertaken by the practice manager following recent training by a fire safety training company. We saw records showed staff had undertaken a recent fire evacuation and had an evacuation plan. Fire extinguishers and fire alarms had been regularly serviced and maintained by external contractors.

The practice ensured risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this and the mitigating actions that had been put in place to manage this. The practice identified there was a potential scalding hazard (for children) in a non - patient area. This was addressed by securing the door and a 'staff only' notice reminder to patients.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). 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. In addition the GPs met regularly as part of the practice journal club where they discussed clinical guidance and research. The records of the most recent meetings demonstrated NICE guidance on the management of atrial fibrillation (Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate) had been discussed.

The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the use of recommended care pathways to manage patients' long term conditions such as asthma and diabetes.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Nursing staff recognised their role responsibilities and boundaries. They told us GPs were approachable and they were able to asking for advice and support about patients treatment. The practice used computerised tools which identified patients with complex needs who had multidisciplinary care plans. We were told the process the practice used to review patients recently discharged from hospital. This ensured the GP saw the discharge notes, how changes to medicines were made and patients records updated.

National data (the Hospital Episode Statistic) showed the practice was in line with regional referral rates to secondary and other community care services for all conditions with the exception of emergency cancer admissions to hospital which were higher. The GPs we spoke with on the day of the inspection suggested this could be due to the higher than average older adult population.

All GPs we spoke with used national standards for the referral of suspected cancer. We saw records which demonstrated the GPs had reviewed each other's elective and urgent referrals to secondary care.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were on appropriate treatment and regularly reviewed.

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 race was not taken into account in this decision-making.

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 data input, clinical review scheduling, child protection alerts and medicines management.

The practice showed us records which demonstrated 19 clinical audits had been undertaken from January 2013 to September 2014. Most of these were prescribing audits. However, examples of other clinical audits included an audit to review the management of patients with contraceptive devices and audits of patient uptake of primary care services provided for example immunisations. We noted the practice had not undertaken an audit to confirm the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. Recommendations from the audits had yet to be re-audited to demonstrate the changes had been implemented and improvements had been made.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF is a national performance measurement tool). For example, we saw an audit regarding the prescribing of anti-inflammatory medicines with medicines to thin blood and the prescribing of the correct dose of antidepressants. This followed guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) (The MHRA is a government agency responsible for ensuring medicines and medical devices are safe) about

Good

Are services effective?

(for example, treatment is effective)

the use of medicines. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 98.5% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease (lung disease) and palliative care. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice supported mothers, children and young people by working with other healthcare providers to provide maternity services. The practice worked collaboratively with other healthcare professionals to support children at risk and their families. Records demonstrated the Lead GP met quarterly with health visitors to review child protection plans and gained feedback from other agencies involved.

Immunisation clinics were led by appropriately qualified and trained nurses and baby health checks were undertaken by the GP. Women were able to attend the well women clinic at the practice for breast examination and cervical smear tests.

The practice delivered enhanced services (locally developed services over and above the essential/ additional services normally provided to patients) to promote sexual health. This included advanced contraceptive services (such as coil insertion). Patients under the age of 25 years had access to chlamydia screening (a sexually transmitted disease).

Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant patient medicines intolerances and allergies when the GP went to prescribe medicines.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area for example, the monitoring of patients with hypertension (high blood pressure)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff with the exception of a newly appointed GP were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors with one GP specialising in gastro-enterology (the digestive system and it's disorders). Another GP and practice nurse had undertaken training in insulin initiation (starting patients on insulin).

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Nursing staff we spoke with indicated the practice did not always support the continuing professional development needs identified as part of their career progression. In addition they identified attendance at study days was sometimes difficult as practice sessions could not be covered.

As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties for example, administration of vaccines, cervical cytology and test to measure blood clotting time. Those nurses with extended roles were also able to demonstrate they had appropriate training to fulfil these roles for example, a Diploma in Diabetes Management.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including

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Are services effective?

(for example, treatment is effective)

discharge summaries, out of hour's providers were received both electronically and by post. All staff we spoke with understood their roles and responsibilities in managing information from other healthcare providers and felt the system in place worked well. We saw the practice followed up results or discharge summaries from other healthcare providers which were expected and had not been received. However, we noted the system to monitor the follow-up of patient test results following minor surgery undertaken in the practice was not consistently completed.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required.

The practice met with members of the multi-professional team formally every three months and informally to review patients' care and support. Records demonstrated safeguarding issues, clinical reviews and care planning were discussed. In addition the practice met every three months with palliative care providers to review patients with palliative and end of life needs.

Information sharing

The practice used a number of electronic systems to communicate with other providers. Electronic systems were also in place for making referrals. (The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported this system was easy to use. Patients' blood and other test results were requested and reported electronically to prevent delays and reduce error. For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E.

The practice had systems in place to provide staff with the information they needed. At the time of the inspection the practice was changing to a new record management system. The system would be used by all staff to coordinate, document and manage patients' care and would enable scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff were in the process of receiving training about the system.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The nursing and medical staff we spoke with about the subject were aware of their responsibilities in applying the principles to their practice. They gave examples of how patients should be supported to make their own decisions. For example, staff stressed the importance of knowing their patients, how they spent time explaining treatments and how they checked patients' understood what was said. They told us how they involved carers with the patient's permission. Nurses referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest. Staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Patients with learning disabilities 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).

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

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. If the patient was taking prescribed medicines then they would be seen by the GP.

Nursing staff used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, offering smoking cessation advice to smokers. There was a health education display in the waiting area and a comprehensive range of health promotion information in the practice and on the website which included mental health advice.

The practice offered NHS Health Checks to all its patients aged 40-75.

Good

Are services effective?

(for example, treatment is effective)

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all these patients were offered an annual physical health check. Nurses offered advice and support for patients who were smokers or wanted to lose weight in line with their needs.

The practice manager told us 91.3% of women aged between 25 and 65 had a cervical smear test in the preceding 5 years. The practice performance for national mammography (in last three years prior to 2013) was significantly different to Gloucestershire CCG (73.9% and 77.1% respectively. Public Health England National Cancer Intelligence Network 2013). The uptake for national bowel screening (within six months of invitation) was not significantly different from Gloucestershire CCG (58.9% and 63.9% respectively. Public Health England National Cancer Intelligence Network 2013)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was above average for the CCG. There was a protocol for following up patients who did not attend clinics or appointments related to health promotion or prevention.

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 120 patients undertaken by the practice in 2013. The evidence from all 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 GP National Patient Survey 2013/2014 showed 96% of respondents described their overall experience of the practice as good. The practice was above the Gloucestershire Clinical Commissioning Group (CCG) average for its satisfaction scores on consultations with GPs and nurses with 95% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 27 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good/excellent service and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven 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 all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice telephones were shielded by glass partitions which helped keep patient information private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP National Patient Survey 2013/14 showed 93% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were above the Gloucestershire CCG average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and confirmed these views.

Nursing staff described examples of how patient choice was respected. For example, some patients were offered options of treatment for managing wounds to minimise disruption to their lifestyle and promote independence.

Staff told us that translation services were available for patients who did not have English as a first language. There was also a link to translations of the website information in a number of different languages.

The practice worked actively with local palliative care services to support patients at the end of their life. Patients and relatives were involved in advance care planning and used a comprehensive locally developed document to record patient's end of life care choices and wishes.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided. For example, 90% of respondents to the GP National Patients Survey said the last GP they spoke with treated them with care and concern when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Good

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available to carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted by their usual GP and were offered emotional support at this difficult time.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

There had been very little turnover of staff during the last three years which enabled continuity of care and accessibility to appointments with a GP of choice. The practice had advertised for a nurse to support their most vulnerable older patients. This was in response to changes in community nursing support and the number of older adults in the practice population. Longer appointments were available for patients who needed them and for those with long term conditions. This included appointments with a named GP or nurse. Home visits were made to two local care homes by a named GP and to those patients who needed one. Patients who were unable to attend the practice due to ill health could request a home visit or telephone consultation. The patient website enabled patients to order a repeat prescription.

The practice was open late one day per week for pre-booked appointments to accommodate patients not able to attend the practice during routine practice hours.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, providing information about how to use the automated telephone system and PPG support for the new practice premises.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings to discuss patient and their families care and support needs. The practice had information readily available on advance care planning to support patients to consider and record their end of life care choices.

The practice delivered an enhanced service (locally developed service over and above the essential/additional services normally provided to patients) which was to co-ordinate and manage the care of frail older people to avoid unplanned admissions to hospital. The practice demonstrated their achievement of this service by regular meetings with other health care providers, the development of patient care plans and the identification of the most vulnerable patients.

Patients on blood thinning medicines were able to have their blood test to determine blood clotting time undertaken at the practice removing the need to travel to the hospital for the same investigation.

The practice worked closely with community groups to enable patients' access to primary care services. For example, utilising the notice boards in the local supermarket to enable key health messages to be shared; working with village agents to support older patients living in isolated conditions and utilising volunteers to deliver prescriptions and bring patients to the surgery during poor weather conditions. We were told some patients appointments were arranged to fit in with a bus service run by volunteers with outreach to villages not covered by commercial services.

For the past two years the practice had organised a 'flu' bus parked in the local supermarket car park and providing flu immunisations for patients without an appointment. This had been evaluated by patients as a useful addition to the services provided by the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the delivery of its services. For example, the practice had acknowledged that specific religious groups living in the area had differing support needs in relation to maternity and palliative care support. Care and support was provided in keeping with the individual patients agreed requirements

The practice kept a record kept of patients living in 'tied' accommodation who might be vulnerable due to their home/living arrangements. The practice were aware of patients who were also carers and provided health screening and immunisations.

The practice had access to online and telephone translation services for patients where English was not their first language.

The practice premises were not purpose built and therefore the access and facilities were not suitable to address the needs of all the patients groups. For example patients using mobility aids or mothers and babies. The practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

had made some adjustments to the building for patients with mobility needs. For example, the provision of a toilet for people with disabilities and access to downstairs consulting rooms for appointments. However, some clinical rooms were too small to allow wheelchair access or the provision of a couch for patients needing to lie down. The doors to the practice were not automated and the reception desk and dispensary hatch were too high to enable face to face communication for patients using wheelchairs. The partners were aware of the shortfalls of the building and had a planning application in process for a new, purpose built practice. We observed staff offered help when they were aware a patient needed to enter the building. The practice had an induction loop system for patients with hearing difficulties. We noted the practice website enabled patients with visual impairment to listen to the website information rather than read it.

Access to the service

Appointments and telephone consultations were available from 8.am to 6.30pm on weekdays. Later evening booked appointments were available one day per week for patients not able to attend during routine practice hours. Patients were able to request a repeat prescription via the practice website by the telephone and practice dispensary.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number which they should ring depending on the circumstances. Information about the out of hour's service was provided to patients.

Patients stated they were generally satisfied with the appointments system. Information from the GP National Patient Survey 2014 demonstrated 95% of respondents said their last appointment was convenient and 90% said their experience of making an appointment was good. They confirmed 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. Patients could make an appointment with their GP and nurse in advance.

Listening and learning from concerns and complaints

The practice has a system for handling formally recorded complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

The practice had received eight complaints received since May 2013 which had been managed in line with the practice policy. Feedback from patients during this inspection told us they had no complaints about the practice. Patients we spoke with said they were confident any concerns would be managed appropriately. We saw the practice did not keep a record of compliments or minor concerns/grumbles which could help improve services.

There was information available to patients in the practice leaflet and on the practice website about who to contact in the practice if they wanted to make a complaint The practice leaflet included information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint.

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 business plan. The emphasis for the practice was the development of purpose built facilities.

The practice values reflected the importance of ensuring high quality primary care provision. Staff we spoke with gave examples of how team work and knowledge of their patients, some over many years enabled a high standard of effective care and treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer. We looked at a range of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. Overall the policies and procedures we looked at had been reviewed and were up to date with the exception of the medicines management operational procedures some of which had not been reviewed since 2012.

The practice held quarterly governance meetings. We looked at minutes from the last three meetings and found performance, quality and risks had been discussed. We saw administration staff were not invited to the incident and adverse events reviews. However, we were told by the practice manager paper copies of minutes were available to staff.

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

The GPs told us about locality learning event where the practice met with other practices in the area. Part of the learning event was to compare and discuss referral and prescribing data.

The practice had completed a number of clinical audits, for example, reviews of patients' medicines, a follow up of patients with contraceptive coils and an evaluation of a risk rating tool to diagnose cancer risk.

The practice had arrangements to identify, record and manage risks. The practice manager showed us their risk log which addressed a wide range of potential issues. Overall risk assessments had been carried out. Where risks were identified and action plans had been produced and implemented. However there were some exceptions for example, the siting of the liquid nitrogen tank in an area which placed staff at potential risk of harm.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example there was a nurse with lead responsibilities for infection control and a two GPs partner had lead responsibilities for safeguarding. Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns.

We saw from meeting minutes that individual team meetings were held regularly, usually monthly. Staff told us they raised issues at their team meetings and took these to the GP partners for resolution if necessary. There was not a whole practice staff meeting however, there was protected learning times scheduled. Staff told us this was a combination of learning and updates. The practice was closed for these events. Patient queries and appointment times were covered by a duty doctor during these closures.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness) which were in place to support staff. These were up to date and reflected current HR procedures.

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

The practice had gathered feedback from patients through patient surveys, complaints and the patient participation group. The results and actions agreed from these surveys were available on the practice website. The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG mostly contained

Are services well-led?

Good

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

representatives from patients not working or retired. The PPG met every quarter with the practice manager and a GP representative and issued a quarterly newsletter updating patients on practice issues and services.

We looked at the results of the PPG annual patient survey (2013) and saw 98% of respondents rated the use of the 'flu' bus as good, very good or excellent. We noted the practice had responded to comments about the difficulties of using the automated telephone system. As a result of this the practice had developed a leaflet to assist patients use the system.

Staff told us they were able to give feedback and discussed any concerns or issues with colleagues and management. Overall staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available for all staff to read and to provide guidance.

Management lead through learning and improvement

Nursing staff told us although they were able to remain updated with mandatory training requirements for example, immunisations other continuing professional development opportunities were more difficult to achieve. Reasons for this were arranging cover to attend training or lack of opportunity to develop skills. Staff were encouraged to attend protected learning events every two months which they said were educational and informative.

We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a GP training practice for medical students and GP registrars specialising in primary medical care.

The practice had completed reviews of significant events and other incidents and shared with staff who did not attend via meeting minutes circulated as an email.

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated management did not always lead through learning and improvement. For example, audit cycles were not completed, action plans were not reviewed and communication across the whole staff group did not always take place. This had the potential for risks to patients and staff to remain unaddressed.