Ley Hill Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ley Hill Surgery on 18 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, and well-led services. We found the practice to be outstanding for providing responsive services. We also inspected the quality of care for six population groups these are, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the care provided to these population groups as good.

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

- There were systems in place to ensure patients received a safe service. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, reviewed and addressed. Risks to patients were assessed and well managed, with the exception of those relating to recruitment procedures which should be improved.
- There were effective arrangements in place to identify, review and monitor patients with long term conditions. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment. The practice demonstrated a caring and compassionate approach to end of life care and bereavement support.
- The practice was responsive to the needs of the practice population. The practice proactively engaged with patients in the local community and had initiated positive service improvements for its patients that were above its contractual obligations.

Summary of findings

- There was strong and visible clinical leadership with defined roles and responsibilities and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice demonstrated a caring and compassionate approach to end of life care and bereavement support. The practice had developed a 'Bereavement Protocol' this enabled the practice to take extra steps to communicate bereavements across departments, services and wider organisations and reduced the risk of inappropriate communications being sent avoiding unnecessary distress to family members and carers. The practice undertook reflection of the end of life care provided to patients and learning was shared with other practices. An audit was completed to ensure patients records clearly recorded their end of life wishes such as where the person would prefer to die.
- There was evidence that the practice was innovative and took a lead role in developing and improving primary care services for the local population. This included an innovative project to reduce unplanned hospital admissions in the elderly as part of the Clinical Commissioning Groups (CCG) 'Aspiring to Clinical Excellence (ACE) Pioneers' programme. The aim was to integrate general practice, community care with hospital care.
- The practice offered a range of in house services such as anti-coagulation services, physiotherapy and a cardiology outreach clinic. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital. One patient commented on how effective this had been for their family member as the nearest hospital was some distance from their home.
- The practice had started a new system where the purpose of a medication was specified on the prescription to ensure patients were given all the relevant information they required.

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

Importantly, the provider should:

- Develop a system to ensure a clear audit trail for stock medicines in use.
- Ensure outstanding actions from completed infection prevention and control audits are acted on.
- Ensure robust recruitment procedures that demonstrate checks required by current legislation have been completed.
- Update the fire risk assessment and ensure risks associated with the general environment such as the control of substances hazardous to health (COSHH) are assessed and managed.

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 good for providing safe services. 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 patients safe. However, the practice should ensure robust recruitment procedures that demonstrate checks required by current legislation have been completed.

Are services effective?

Good

The practice is rated good for providing effective services. Data showed patient outcomes were about average in comparison to other practices nationally. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely.

Clinical audits were completed to ensure patients' care and treatment was effective. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. There was evidence of effective multi-disciplinary working to ensure a coordinated approach to managing people with complex, long term conditions and those in high risk groups. For example, there was joint working arrangements with the mental health service, community matrons, health visitors and other local GP practices.

Are services caring?

Good

The practice is rated good for providing caring services. Data showed that patients rated the practice about average in comparison to other practices nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment. Information to help patients understand the services was available and easy to understand.

The practice demonstrated a caring and compassionate approach to end of life care and bereavement support. The practice had developed a 'Bereavement Protocol' which enabled the practice to

Summary of findings

take extra steps to communicate bereavements across departments, services and wider organisations this reduced the risk of inappropriate communications being sent and avoiding unnecessary distress to family members and carers. The practice undertook a reflection on the end of life care provided to patients and learning was shared with other practices. An audit was completed to ensure patients records clearly recorded their end of life wishes such as where the person would prefer to die.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice worked closely with two other local practices to initiate an innovative project to reduce unplanned and inappropriate hospital admissions in the elderly as part of a Local Commissioning Network (LCN). The aim was to integrate general practice, community care with hospital care.

The practice was proactive in identifying and supporting the needs of vulnerable patients. For example, undertaking a carers event and providing a carers pack with information for support groups and services for carers to help promote good health and wellbeing. The practice had a higher than national average practice population aged 65 years and over. There was evidence that GPs undertook a high number of home visits a day for those patients who were unable to attend the practice that demonstrated a willingness to meet the needs of the practice population.

The practice offered a range of in house services such as anti-coagulation services and physiotherapy. They also had a cardiology outreach clinic from University Hospitals Birmingham. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital. Two of the GPs were Royal College of General Practitioners (RCGP) trained drug misuse prescribers and worked in conjunction with a drug support worker (in the practice).

Patients were able to access urgent appointments usually on the same day by way of two urgent surgeries where patients could be reviewed. Access to routine appointments and the ability to get through on the telephone were issues that patients felt needed to improve however; the practice had identified these and was working to improve access.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

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Are services well-led?

Good

The practice is rated good for providing well-led services. It had a clear vision and strategy and staff were aware of their responsibilities in relation to this. There was strong and visible clinical leadership with defined roles and responsibilities and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings to discuss how the practice was progressing in areas such as the Quality Outcome Framework (QOF). 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

There was evidence that the practice was innovative and took a lead role in developing and improving primary care services for the local population. This included an innovative project to reduce unplanned hospital admissions in the elderly as part of the Clinical Commissioning Groups (CCG) 'Aspiring to Clinical Excellence (ACE) Pioneers' programme. The practice was also a lead for a total of 49 practices in bidding for the 'Prime Minister's Challenge Fund' to deliver better access in an innovative way.

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 good for the care of older people. The practice had a higher older practice population aged 65 years and over in comparison to the national average. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked in conjunction with the multidisciplinary team to identify and support older patients who were at high risk of hospital admissions.

People with long term conditions

Good

The practice is rated good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care.The practice undertook prevalence searches which enabled them to identify patients with long term conditions and those in high risk groups. This ensured they were added to the appropriate registers and could be easily identified and offered regular reviews of their health needs.

Families, children and young people

Good

The practice is rated good for the care of families, children and young people.There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours .There was evidence of joint working arrangements with the midwives and health visitors and systems in place for information sharing.

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Working age people (including those recently retired and students)

Good

The practice is rated good for the care of working age people (including those recently retired and students).The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice was open extended hours to accommodate the needs of working age patients.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those with caring responsibilities. It had carried out annual health checks for people with a learning disability and offered longer appointments .The practice regularly worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of contacting relevant agencies in normal working hours and out of hours.

The practice provided an enhanced service to avoid unplanned hospital admissions. This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. It carried out advance care planning for patients with dementia. Staff worked closely with local community mental health teams to ensure patients with a mental health need were reviewed, and that appropriate risk assessments and care plans were in place. The practice hosted Birmingham Healthy Minds which was a mental health service to help facilitate access to psychological support, and there were weekly visits from a service that supported people who had alcohol dependency. Two of the GPs were Royal College of General Practitioners (RCGP) trained drug misuse prescribers and worked in conjunction with a drug support worker (in the practice).

Summary of findings

The practice undertook a dementia coding exercise which identified 198 patients who were not on the dementia register. The notes of these patients were reviewed by doctors in the practice and resulted in action being taken to ensure patients needs were assessed appropriately. The practice sign posted patients experiencing poor mental health to various support groups and voluntary organisations.

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What people who use the service say

We looked at results of the most recent national GP patient survey 2013- 2014. Findings of the survey were based in comparison to the average for other practices nationally. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. This included patients experience of getting through to the practice by phone, opening times and patients overall experience of their GP practice. There were two areas in which the practice was below average, these were the number of patients who stated that in the reception area they could be overheard and being able to see or speak with their preferred GP.

We reviewed comments made on the NHS Choices website to see what feedback patients had given over the last year. There were three comments posted on the website which included a mixture of positive and negative feedback. The practice had not replied to any of the comments.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 10 completed cards, the feedback we received was overall positive. On the day of the inspection we spoke with six patients including two member of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described staff as caring and helpful and said their privacy and dignity was respected. However, some patients told us that access to appointments and the length of time they waited to be seen by the GP on arrival at the practice could be improved.

Areas for improvement

Action the service SHOULD take to improve

- Develop a system to ensure a clear audit trail for stock medicines in use.
- Ensure outstanding actions from completed infection prevention and control audits are acted on.
- Ensure robust recruitment procedures that demonstrate checks required by current legislation have been completed.
- Update the fire risk assessment and ensure risks associated with the general environment such as the control of substances hazardous to health (COSHH) are assessed and managed.

Outstanding practice

- The practice demonstrated a caring and compassionate approach to end of life care and bereavement support. The practice had developed a 'Bereavement Protocol' this enabled the practice to take extra steps to communicate bereavements across departments, services and wider organisations and reduced the risk of inappropriate communications being sent avoiding unnecessary distress to family members and carers. The practice undertook reflection of the end of life care provided to patients and learning was shared with other practices. An audit was completed to ensure patients records clearly recorded their end of life wishes such as where the person would prefer to die.
- There was evidence that the practice was innovative and took a lead role in developing and improving primary care services for the local population. This included an innovative project to reduce unplanned hospital admissions in the elderly as part of the

Summary of findings

Clinical Commissioning Groups (CCG) 'Aspiring to Clinical Excellence (ACE) Pioneers' programme. The aim was to integrate general practice, community care with hospital care.

- The practice offered a range of in house services such as anti-coagulation services, physiotherapy and a cardiology outreach clinic. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital. One patient commented on how effective this had been for their family member as the nearest hospital was some distance from their home.
- The practice had started a new system where the purpose of a medication was specified on the prescription to ensure patients were given all the relevant information they required.

Ley Hill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team also included a specialist advisor GP and a specialist advisor practice manager who have experience of primary care services.

Background to Ley Hill Surgery

Ley Hill Surgery is based in a two storey building that has undergone extension and has a registered patient list size of approximately 12000 patients.

The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and a teaching practice for medical students in both foundation and final year of training.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some enhanced services. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice is open Mondays to Fridays 8am to 6:30pm and includes an extended hours service two days a week when the practice is open between 6:30pm and 8.15pm which would benefit working age patients. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'Badger' the external out of hours service.

There are eight GPs working at the practice which includes one salaried GP and seven GP partners and also includes a number of male and female GPs. The practice employs four practice nurses and a health care assistant all of whom are female. There are also eight administrative staff, 13 reception staff an assistant practice manager and a practice manager. At the time of the inspection two of the partners were new to the practice and had not registered with the Care Quality Commission (CQC). We discussed this with the lead GP and the practice manager who assured us this would be completed.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of the least deprived areas in Birmingham. The practice has a higher than national average practice population aged 0 to 4 years and 65 years and over, and a slightly higher than national average practice population with caring responsibilities. The practice achieved 98.2 % of points for the Quality and Outcomes Framework (QOF) for the last financial year 2013-2014. This was above the average practice score nationally. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice. We also asked other organisations to share what they knew. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 10 completed cards where patients shared their views and experiences of the service. We carried out an announced visit on 18 February 2015. During our inspection we spoke with a range of staff including the management team, clinical and non clinical staff. We also spoke with patients who used the service.

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw an example of a prescribing incident that was reported, well documented and appropriate action taken.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 year and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda. There was evidence that the practice had learned from these, action taken and that the findings were shared with relevant staff. We saw evidence of action taken and changes made a result of a significant event to prevent re occurrence. For example, the system to monitor and record the professional registration details for staff had been improved. This was as a result of a lapse in a staff member's registration, this had also been addressed by the NHS England Area Team. 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 or one of the GP partners. We tracked two incidents and saw records were completed in a comprehensive and timely manner.

National patient safety alerts were disseminated by one of the GPs and acted on where appropriate and shared with staff. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. There was evidence of regular meetings with the health visiting team to ensure information sharing, identification and follow up of at risk children.

The practice had appointed a GP with a lead role 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 with 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.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

There were four dedicated secure fridges where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperatures were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use.

Good

Are services safe?

The practice routinely used electronic prescribing. There was a clear audit trail to ensure all prescriptions including paper prescriptions could be accounted for.

There were robust arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. There was an alert system which informed patients and staff that medication reviews were due.

The practice had also started a new system where the purpose of a medication was specified on the prescription to ensure patients were given all the relevant information they required. A pharmacist from the local Clinical Commissioning Group (CCG) was attached to the practice. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. We spoke with the pharmacist who told us they undertook regular visits to the practice and worked with the clinicians to enable medicine management systems to be monitored and reviewed such as prescribing audits. The most recent data available to us showed that the practice prescribing rates for some medicines for example Non-Steroidal Anti-Inflammatory were in line with the national average.

The practice did not have any controlled medicines but stored a small quantity of stock medicines however, we saw that the stock control for these were mostly visual checks and no records were kept.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment (PPE) and posters promoting good hand hygiene. There was an infection control policy which had been recently reviewed and a named lead for infection control with responsibility for overseeing good infection control procedures. We saw evidence that a number of staff had received training in infection prevention and control so that they were up to date with good practice. We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste. The practice employed cleaners for the general cleaning of the environment and there were records to demonstrate the cleaning undertaken.

An infection prevention and control audit had been completed by the Clinical Commissioning Group (CCG) in March 2014. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. There was evidence that some of the actions identified from the audit had been addressed and others were in progress. For example, the audit identified that the carpets in two of the consulting rooms should be replaced with a washable hard surface flooring, the manager told us that this was due to be replaced within the next month. However, one of the actions included developing an equipment cleaning checklist, the manager was unable to confirm that this had been developed. The infection control lead at the practice had also completed an internal audit in November 2014 and identified two areas for improvement. These related to the cleaning of the environment and included ensuring domestic staff changed the mops used for cleaning daily and only used single use cloths. However, there was no evidence to demonstrate the actions taken to address the issues.

There were no records of a Legionella test or risk assessment. Legionella is a term for particular bacteria which can contaminate water systems in buildings. However, we saw evidence that the practice had obtained a quote for although no date had been confirmed. Following our inspection the practice sent us confirmation of a completed Legionella risk assessment undertaken.

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 blood pressure measuring devices.

Fire alarms, equipment and emergency lighting were checked to ensure they were in good working order

Good

Are services safe?

Staffing and recruitment

Records we looked at contained some evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). A DBS check helps to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had a recruitment policy that set out the standards it followed when recruiting staff although the policy was not detailed as it made no reference to the need for DBS checks. We also saw that there were some gaps in the recruitment procedure. We looked at the file of the most recently employed clinical staff. We saw that they had started their post without a DBS check however, we saw evidence that a request for a check was now in progress. Following our inspection we received confirmation from the practice that this had now been completed. This member of staff also had only one reference requested although the practice protocol for recruitment reference stated at least two references would be sought; there was also no medical health information for this member of staff. The lead GP acknowledged that the recruitment process for this had not been as robust as they were someone who was known to the practice.

We identified during our discussions with non clinical staff that they sometimes acted as chaperones. However, we saw that they did not have a DBS checks or risk assessment in place which took into account potential risks such as if they would be left unattended with a patient. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. There was no documented risk assessment however, there was evidence that the practice had considered the risk and as a result a DBS check for all non clinical staff acting as chaperones was in progress. Following our inspection we received confirmation from the practice that this had now been completed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included a health and safety policy and an identified health and safety representative. Risks were routinely discussed at the GP partners' meetings and within team meetings. Staff had received training in fire safety in 2013 although no further updates had been undertaken, there was evidence that regular fire drills took place to ensure staff were prepared in the event of a fire emergency. However, there were some gaps, an annual fire risk assessment was last completed in July 2013 and was due to be reviewed in July 2014 but this had not taken place. There was no general health and safety risk assessment which covered potential risks relating to the environment and the practice did not have data log sheets for the control of substances hazardous to health (COSHH) to ensure an accurate record of all COSSH products.

Arrangements to deal with emergencies and major incidents

There were arrangements to deal with foreseeable medical emergencies. Staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. The practice had oxygen and automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines and equipment.

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

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. Weekly clinical staff meetings and protected learning time provided the opportunity to discuss and share best practice. There were examples of the practice implementing best practice in line with NICE. For example, adherence to NICE guidelines for the investigation and treatment of patients with Deep Vein Thrombosis (DVT) to achieve the best health outcome. We found from our discussions with the GPs and nurses and review of care plans that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs at the practice had lead roles in specialist clinical areas such as diabetes, women's health and palliative care and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

The practice had an effective system in place for identifying and reviewing patients with long term conditions. Data that we reviewed showed that the practice was line with the national average in areas such as diabetes, mental health and palliative care.

All GPs we spoke with used national standards for any urgent referrals to secondary care for example for suspected cancer.

The practice undertook a dementia coding exercise to help identify coding abnormalities that may have contributed to a discrepancy between patients on the dementia register and predicted prevalence. This enabled the practice to identify 198 patients who were not on the dementia register. The notes of these patients were then reviewed by GPs in the practice and resulted in action being taken to ensure patients needs were assessed appropriately.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The practice achieved 98.2 % of points for the QOF for the last financial year 2013-2014. This was above the average practice score nationally.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (COPD) (lung disease). The practice carried out prevalence searches for long term conditions such as hypertension, diabetes, learning disabilities, and COPD. This led to the practice identifying patients who were not on the appropriate register, this then enabled the practice to add patients to the register and deliver a more structured care programme.

The practice had a system in place for completing clinical audit cycles. The practice had completed eight clinical audits in the last year. Audits were completed cycles which showed improvements made to patients care and treatment and demonstrated good learning and reflection. For example, following an audit which looked at blood pressure monitoring for patients on a particular medicine, systems were implemented to ensure these patients had regular blood pressure checks undertaken, the results were re audited and demonstrated significant improvements.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice had implemented the gold standards framework for end of life care (GSF). The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. It had a palliative care register and developed

Good

Are services effective?

(for example, treatment is effective)

a detailed spreadsheet which contained summary notes that included important information so that the patients needs could be easily identified. There were regular multidisciplinary meetings to discuss the care and support needs of patients and their families

GPs in the surgery undertook minor surgical procedures (joint injections) in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out audits on their results and used that in their learning.

Effective staffing

The GPs at the practice were GP trainers, appraisers and honorary lecturers who worked with the local deanery and universities to support GP registrars and medicals students. Some were fellows of The Royal College of General Practitioners (RCGP). Fellowship is the highest level of membership given in recognition of a significant contribution to medicine. They also had various roles within the Clinical Commissioning Group (CCG) such as Clinical Lead in Primary Care Quality and Education. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice had an established team that included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with courses such as basic life support and safeguarding children and vulnerable adults. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and spirometer. Those with extended roles such as reviewing patients with long-term conditions such as asthma, diabetes and respiratory conditions were also able to demonstrate that they had appropriate training to fulfil these roles. The practice had supported staff with their professional development. For example, one member of staff had been provided the opportunity to undertake a leadership course another had been supported to train as a nurse.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had completed a spirometry course. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

There were no joint practice meetings which included staff such as administrative and clinical staff and some staff felt this would be helpful in promoting a team environment. However, there were regular meetings for each staff groups such as the GPs, nursing and administrative staff.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were systems in place to ensure that the results of tests and investigations were reviewed and acted on as clinically necessary by the requesting GP. The practice had an effective referral system to secondary care services. The referral and letter for secondary care services were completed together to ensure all of the appropriate information was forwarded.

Multidisciplinary working was in place, meetings were held with health care professionals such as the district nurses and palliative care nurses as part of the GSF. The practice also held monthly meetings with the health visitors to discuss the needs of children on the at risk register. We spoke with the health visiting team who told us that they felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information.

Good

Are services effective?

(for example, treatment is effective)

The practice hosted Birmingham Healthy Minds which was a mental health service to help facilitate access to psychological support, and there were weekly visits from a service that supported people who had alcohol dependency.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had completed the required 2% of care plans and regularly reviewed them.

Information sharing

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

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen. There were also systems in place to monitor urgent referrals to ensure these were completed in a timely manner and any lapses in the process identified and acted on.

Our discussion with health care professionals and evidence from meeting minutes reviewed on the day demonstrated that information was shared in a timely manner.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had a clear policy on assessing capacity providing guidance to staff. There was an electronic template to record capacity assessment which then automatically uploaded on to the patients medical records to provide an audit trail.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). We saw an example of a care plan which was comprehensive and demonstrated patients involvement in their care. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

Information leaflets and posters were available in the patient waiting area relating to health promotion and prevention. There was also information that signposted patients to support groups and organisations such as services for people who were carers. The Patient Participation Group (PPG) had undertaken a carers event and health awareness day with two other PPG groups from local practices. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service The aim was to support the health and wellbeing of people with caring responsibilities as they had recognised this was a vulnerable group who maybe experiencing stressful circumstances and potential social isolation. The event was also attended by a nurse to offer the flu jab opportunistically as well as a mental health support worker to offer advice and support.

The practices website had information and links to patient information on various health conditions such as, diabetes as well as advice on self-care for treating minor illnesses.

The practice offered advice and support in areas such as smoking cessation, weight management, family planning and sexual health referring patients to secondary services were necessary. NHS health checks were available for people aged between 40 years and 74 years and the practice offered a range of health promotion and screening services which reflected the needs of this patient group. Flu vaccinations were offered to high risk groups.

The practice had a policy and procedure in place for new patients registering with the practice. This included completing a new patient medical assessment. The GPs were informed of all health concerns detected and these were followed up in a timely way.

There was a national recall system in place for cervical cytology screening in which patients were invited to attend the practice. Cytology screening was undertaken by the

Good

Are services effective?

(for example, treatment is effective)

practice nurse. This ensured women received this important health check including their results in a timely manner. Findings were audited to ensure good practice was being followed.

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 2013- 2014. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. For example, data showed the practice was rated average for the proportion of respondents who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. The practice was rated better than average for the proportion of respondents who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. The practices own internal patient survey showed that 93% of respondents rated their experience of the practice as satisfactory, good or very good.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said staff treated them with dignity and respect. 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.

The layout of the patient waiting area meant that patient's confidentiality may not always be maintained. Patients could be overheard when talking to staff. This was an area where the practice scored below average in the national GP survey 2013- 2014. However, we observed that there were now arrangements in place to help maintain confidentiality. There was a 'Privacy Zone' and a poster informing patients that they could discuss any issues in private, away from the main reception desk. In some areas music was used to mute conversations in consulting rooms that could be overheard by patients waiting outside. We observed staff were careful in what they discussed with patients approaching the reception desk. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients privacy and dignity was maintained during examinations, investigations and treatments. We also noted that consultation and treatment room doors were closed during consultations.

Patients were offered a chaperone for intimate examinations and procedures and our discussions with staff demonstrated that they were aware of the importance of maintaining patient's dignity and respect during such procedures. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

There were male and female GPs employed at the practice. This gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

Data from the national GP patient survey 2013-2014 showed that patients generally rated the practice in line with other practices nationally in response to questions about their involvement in planning and making decisions about their care and treatment. For example, the number of respondents who said the last time they saw a GP the GP was good or very good at involving them in decisions about their care was about 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 aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website had the facility to enable information to be translated into a number of languages. There were arrangements in place to book a sign language interpreter for patients with a hearing impairment.

Patient/carer support to cope emotionally with care and treatment

There was a notice board in the patient waiting area with information for carers which included details of how to access support groups and organisation to ensure this vulnerable group understood the various avenues of support available to them. The practice also had an alert system for identifying people who were carers to ensure their needs were identified and support could be offered.

Good

Are services caring?

The practice had a Carers Support Scheme as they had recognised the high level of stress that carers may experience, as a result a carer packs was made available which signposted people to support agencies.

Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A patient who spoke with on the day told us that their family member had received compassionate end of life care from staff at the practice. We saw that the practice had developed a 'Bereavement Protocol' this enabled the practice to take extra steps to communicate bereavements across departments, services and wider organisations; cancelling notifications and correspondences such as secondary care referrals and repeat medications. This reduced the risk of inappropriate communication being sent and avoided unnecessary distress to family members and carers. The practice undertook reflection of the end of life care provided to patients and learning was shared with other practices. The practice had also completed an audit to ensure patients records clearly recorded their end of life wishes such as where the person would prefer to die.

Outstanding ☆

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 GPs, practice manager and staff were able to demonstrate insight into the needs of their patients and the challenges they faced.

There was evidence that the practice was proactive in responding to the needs of vulnerable groups by joint working arrangements with the patient participation group (PPG) from two other local practices. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Data that we reviewed from Public Health England showed that the practice had a higher than the national average practice population with caring responsibilities which the practice was also aware of. In response to this the PPG had organised a carers health awareness day with the aim to improve the health and wellbeing of carers.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. This had resulted in exploring ways to improve access to appointments by reducing pressures on the service. For example, supporting people who may attend the GP practice because they were socially isolated although medically well and promoting online booking system via the PPG newsletter.

The practice worked closely with two other local practices to initiate an innovative project to reduce unplanned and inappropriate hospital admissions in the elderly as part of a Local Commissioning Network (LCN). The aim was to integrate general practice, community care with hospital care. They were also part of the Clinical Commissioning Groups (CCG) 'Aspiring to Clinical Excellence (ACE) Pioneers' programme. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. ACE is a programme of improvement aimed at reducing the level of variation in general practice by bringing all CCG member practices up to the same standards and delivering improved health outcomes for patients. There are two levels; ACE Foundation and ACE Excellence and achievement of ACE is verified by a practice appraisal process. Together with the two neighbouring practices, the practice had employed two community matrons to focus on the care needs of older patients. Their role involved liaising with the discharge liaison nurse at the local hospital and reviewing all discharges of patients aged 70 years and over. We spoke with the community matron who told us they worked effectively with the practice in bridging the gap between the community and hospital care. The role of the matron included reducing hospital re-admission and completing post discharge reviews of patients identified ensuring early and safe discharge back to the community. The matrons were able to identify these patients as notifications were sent via an urgent care dash board. A social worker also attended the practice every month as part of the ACE Excellence programme providing the opportunity to discuss patients who may require assessment and support.

The practice had a higher than national average practice population aged 65 years and over. There was evidence that GPs undertook a high number of home visits a day for those patients who were unable to attend the practice that demonstrated a willingness to meet the needs of the practice population. We spoke with a manager of a local care home who gave positive feedback on how the practice supported older patients living in the care home.

The practice offered a range of in house services such as anti-coagulation services and physiotherapy. They also had a cardiology outreach clinic from University Hospitals Birmingham. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital. One patient commented on how effective this had been for their family member as the nearest hospital was some distance from their home.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them. There was evidence that practice was leading on initiatives to improve access to appointment for patients based on local needs and to enable service improvement. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Tackling inequity and promoting equality

There were baby changing facilities at the practice which would be helpful for parents with babies and young children.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a loop induction system available to support people with hearing impairments.

We saw that there were some arrangements for patients with a physical disability to access the service. There were disabled toilet facilities and allocated parking bays. There were lifts to the first floor of the building and the first set of doors to the practice were automatic. However, patients would have to negotiate access via the second set of doors as this was not automatic. Staff told us that they would be able to see patients requiring assistance from the reception area and would assist them. The practice had completed a Disability Discrimination Act (DDA) audit in December 2014 to assess compliance with the Equality Act (2010). This act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. However, this had not identified that the second set of doors could cause difficulties for patients who use a wheelchair.

Access to the service

The practice was open Mondays to Fridays 8am to 6:30pm and included an extended hours service two days a week when the practice was open between 6:30pm and 8.15pm which would benefit working age patients. The practice had opted out of providing out-of-hours services to their own patients. The practice had a walk in system each morning and afternoon where patients could see a GP without an appointment.

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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The PPG had also included information on accessing appointments in their newsletter to raise patients awareness.

Longer appointments were also available for patients who needed them for example, patients with a learning disability or those with a hearing impairment.

Results of the national GP survey 2013-2014 showed that the practice was below the national average for the proportion of respondents to the GP patient survey who stated that they always or almost always see or speak to the GP they prefer. Our discussions with patients on the day of the inspection and feedback from completed comment cards suggested patients were generally satisfied that they could get an urgent appointment on the same day when needed. The main issue for improvement that patients commented on was getting through on the telephone and routine appointments. These were areas that the practice were exploring via the PPG and the practices internal survey. There was also evidence of actions taken by the PPG to help improve this. In recognition of access issues particularly for working age people the practice was the lead practice for a total of 49 practices in bidding for 'Prime Minister's Challenge Fund'. The intention was to deliver better access in an innovative way. At the time of the inspection, the bid had been advanced to the small shortlist at the national level.

Listening and learning from concerns and complaints

The practice had a system in place for handling 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.

We saw that information was available to help patients understand the complaints system; this included a poster in the patient waiting area and a complaints leaflet. Patients we spoke with had not ever needed to make a complaint about the practice but were aware of what to do in the event they did need to raise a complaint or concern.

We looked at four complaints received in the last 12 months and found these were handled satisfactorily and resolved. There was evidence that lessons learned from complaints were shared with staff with changes made.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and ongoing development plan. These values were clearly articulated to the inspection team as part of a practice presentation. The practice vision and values included compassionate, patient centred care and working as a team and with other agencies in the best interest of patients. We saw areas of outstanding practice that supported the practices vision and aspirations.

Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures for example, there were processes in place to keep staff informed and engaged in practice matters which included protected learning time and regular staff meetings held which provided the opportunity to discuss significant events, complaints and share good practice. The GPs at the practice had various lead roles in areas such as mental health, safeguarding and women health This provided the opportunity for staff to develop specialist knowledge and expertise and for other staff to obtain support and advice.

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 within the practice. We looked at some of these policies and procedures and found that most had been reviewed and were up to date. However, some policies lacked detail and should be reviewed to ensure they remained relevant.

There were systems in place to monitor and review the practice performance for Quality and Outcomes Framework (QOF) this included a GP lead for QOF and regular meetings to discuss and monitor performance. Data that we reviewed showed that the practice was a high performing QOF practice and on target to meet its points for the current financial year 2014 to 2015. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

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, prescribing audits to help improve outcomes for patients on a particular medicine.

The GP partners at the practice attended meetings with the local Clinical Commissioning Group (CCG) NHS Birmingham Crosscity. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. This ensured they were up to date with any changes. Feedback we received from the CCG and NHS England Local Area Team suggested that the practice engaged well with them and staff members were actively involved in supporting CCG initiatives.

Leadership, openness and transparency

There was evidence that the practice worked alongside the patient participation group (PPG) and acted on patient feedback which had resulted in changes being made. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Newsletters provided the opportunity for the practice and PPG to engage with patients. The assistant practice manager and a GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

The practice gathered feedback from the staff generally through appraisals, meetings and informal discussions. Staff we spoke with told us that they felt listened to and said they felt comfortable to add anything they wish to discuss as an agenda for staff meetings.

We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff 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 the PPG, patient surveys and complaints received. We looked at the results of the annual patient survey completed from February 2014 to March 2014. The results

Are services well-led?

Good

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

showed that 28% of patients rated their ability to get through to the practice on the phone as poor and 34% stated they waited more than five working days to see a doctor for a routine, non-urgent appointment. The practice had an active PPG that met every month and we saw that as a result of this the practice PPG was exploring ways to improve access to appointments and improve the telephone system. The PPG had carried out regular surveys and we saw the analysis of the last patient survey. The results and actions agreed from these surveys were also available on the practice website.

The practice had 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. There was evidence of training provided to staff to support their professional development. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended.

There was a visible leadership structure and staff members who we spoke with were clear about their roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice was a GP training practice with GPs involved in teaching roles for trainee GPs and medical students. This was reflected in the delivery of care and treatment which was evidence based.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.