Teams Medical Practice

Quality Report

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Date of inspection visit: 13 January 2015
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Team Medical Practice on 13 January 2015. Overall the practice is rated as outstanding. An innovative, caring, effective, responsive and well-led service is provided that meets the needs of the population served.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised, external agencies were informed of the outcome if they were involved. There were strong comprehensive safety systems in place.
- The practice had scored very well on clinical indicators within the quality outcomes framework (QOF). They achieved 99.8% for the year 2013/14, which was above the average in England of 96.47%. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patients commented that they thought they received a very good service from the practice.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients we spoke with and comments cards indicated that it was relatively easy to obtain an appointment. Some patients told us they had changed practices to Teams Medical Practice from other local practices for this reason; the practice had a good reputation in relation to patients being able to obtain an appointment.

We saw several areas of outstanding practice including:

- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, they offered dedicated services for substance misuse. The lead GP had a clinical interest in this area; they were a research associate in substance misuse, at a local university. There were two clinics a week and close working with the substance misuse team.

Summary of findings

- The latest GP Patient Survey completed in 2013/14 showed almost all patients were very satisfied with the services the practice offered. The proportion of patients who would recommend this practice was 97.5%, which far exceeded the national average of 79.1%.
- All Staff received 360 degree feedback every year as part of the appraisal process. 360 degree feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. This shows the practice used innovative approaches to gather feedback from staff.
- The practice were innovative in their attempts to engage with patients and made use of social media to do this. For example they had introduced a Facebook page and twitter account in recent months to engage with patients, patients could also sign up to receive the practice newsletter by email.
- There was good leadership and a strong learning culture and the staff had a clear vision, with quality and safety as their top priority. Staff responded to change and were encouraged to bring suggestions for improvement. We saw a high level of constructive staff engagement and staff satisfaction.

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?

Outstanding 

The practice is rated as outstanding for providing safe services. Patients and staff were protected by strong comprehensive safety systems and the practice was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. We found systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and they linked with other local providers to share best practice. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice were able to show us examples of staff appraisals and their personal development plans. Staff worked well with multidisciplinary teams.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice much higher than others for almost all aspects of care, for example the proportion of patients who said their GP was good or very good at treating them with care and concern was 94%, the national average was 85%. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients told us it was easy to obtain an appointment. Data from the national GP survey showed that 92% of patients reported a good experience of making an appointment, the national average is 78%. The practice had an access protocol which set out how staff were to respond to demand and how it was to be monitored.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and they had an active patient participation group (PPG).

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. Patients aged 75 and older had a named GP. The practice offered personalised care to meet the needs of the older people in its population. This included developing care plans for their most at risk patients, which included patients who were housebound.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the population group of people with long term conditions. There were aspects of the practice which were outstanding and related to all population groups. Patients had reviews to check their health and medication needs were being met. Where possible the practice completed reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions.

For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care and the care is GP led. The practice GPs checked the patient notes of every patient who had not attended a chronic disease appointment to ensure that further appropriate protective steps could be taken to contact the patients if they were thought to be vulnerable.

The Foundation Trust had met with the practice to share and discuss the practice systems for diabetes care and the management of complex patients.

The practice had recently received funding to set up clinics to develop pathways for patients with other chronic diseases such as coeliac disease.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the population group of families, children and young people. There were aspects of the practice which were outstanding and related to all population groups. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice had a vulnerable children protocol.

The practice had a close working relationship with the local health visiting team and one of them attended the monthly

Summary of findings

multi-disciplinary team meeting at the practice to discuss children and families where there were safeguarding or other concerns. The practice also held quarterly meetings specifically to discuss safeguarding.

The practice offered regular baby clinics which were multi-disciplinary involving the health visitor, practice nurse and a GP; immunisations were available for all children every week both in the baby clinic and at other times for older children. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the population group of the working-age people (including those recently retired and students). There were aspects of the practice which were outstanding and related to all population groups. 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. Appointments were available outside normal working hours.

The practice offered a full range of health promotion and screening which reflected the needs for this age group. This included the development of a fitness project led by the practice in partnership with a local sports club.

The practice offered on-line services which included appointment booking and repeat prescriptions. There was also a repeat prescription telephone service available 24 hours a day. They offered a text reminder service to patients to remind them of their appointments.

The practice had introduced a Facebook page and twitter account in recent months to engage with patients, patients could also sign up to receive the practice newsletter by email.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. There were aspects of the practice which were outstanding and related to all population groups. The practice held a register of patients with learning disabilities. The practice had carried out health checks for people with learning disabilities. The practice offered longer appointments for people, if required.

Summary of findings

The practice worked with multi-disciplinary teams in the case management of vulnerable people. 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 how to contact relevant agencies in and out of hours.

The practice offered dedicated services to specific vulnerable groups for example, they held two clinics a week for patients with substance misuse problems they and worked closely with the local substance misuse team who were based at the practice two days a week. The practice staff had received training to enable them to meet the health needs of people with a caring responsibility. Health checks were provided for carers.

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were outstanding and related to all population groups. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

The practice had developed a care plan with all patients who had dementia. They had recently carried out an audit of patients using the Dementia Toolkit to help to identify patients with the condition and to validate the register they held.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection. All of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. Patients commented that they thought they received a very good service from the practice.

We reviewed 47 CQC comment cards completed by patients prior to the inspection,. Comments were overwhelmingly positive. Common words used by patients included “excellent”, “helpful” and “professional”. Several people commented on the high quality of the care they received and also that it was easy to book an appointment.

The latest GP Patient Survey completed in 2013/14 showed most patients were very satisfied with the services the practice offered. Results were well above the national average. The results were:

- Percentage of patients who would recommend the practice – 97.5% (national average 79.1%);
- Percentage of patients satisfied with phone access – 92.5% (national average 77.6%);
- GP Patient Survey satisfaction for opening hours – 86.2 (national average 79.9%).

Outstanding practice

- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, they offered dedicated services for substance misuse. The lead GP had a clinical interest in this area; they were a research associate in substance misuse, at a local university. There were two clinics a week and close working with the substance misuse team.
- The latest GP Patient Survey completed in 2013/14 showed almost all patients were very satisfied with the services the practice offered. The proportion of patients who would recommend this practice was 97.5%, which far exceeded the national average of 79.1%.
- All Staff received 360 degree feedback every year as part of the appraisal process. 360 degree feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. This shows the practice used innovative approaches to gather feedback from staff.
- The practice were innovative in their attempts to engage with patients and made use of social media to do this. For example they had introduced a Facebook page and twitter account in recent months to engage with patients, patients could also sign up to receive the practice newsletter by email.
- There was good leadership and a strong learning culture and the staff had a clear vision, with quality and safety as their top priority. Staff responded to change and were encouraged to bring suggestions for improvement. We saw a high level of constructive staff engagement and staff satisfaction.

Teams Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor and a member of CQC administration staff.

Background to Teams Medical Practice

The area covered by Teams Medical Practice is mainly the postcodes of NE8 and NE11. The surgery building is located in the Teams area of Gateshead close to the main A184 road.

The index of multiple deprivation (IMD) placed the practice in band one for deprivation, where one is the highest deprived area and six is the least deprived.

The practice has four GPs partners, two male and two female. The practice is a training practice. There are two practice nurses and one health care assistant. There is a practice manager, practice pharmacist, reception and administrative staff.

The practice provides services to approximately 5,000 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The service for patients requiring urgent medical attention out of hours is provided by the 111 service and Gateshead Community Based Care Limited, which is also known locally as 'GatDoc'.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and NHS England.

We carried out an announced visit on 13 January 2015. During our visit we spoke with a range of staff. This included GPs, the practice manager, practice nurses, a healthcare assistant, reception and administrative staff. We also spoke with five patients. We reviewed 47 CQC comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with two healthcare professionals attached to the practice.

Outstanding ☆

Are services safe?

Our findings

Safe track record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us at the time of the inspection indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example, it was found that there were errors in the medication of a patient who was discharged from hospital. This was recorded and the GP contacted the consultant at the hospital to ensure the correct medication was given.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings; the records of clinical meetings were available from 2004 to the present day. These showed the practice had managed these consistently over time and so could demonstrate 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. They were open and transparent when there were near misses or when things went wrong. The practice manager told us that they reviewed any safety alerts as to the urgency of the alert and they were then disseminated via email or at meetings. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice.

The practice manager told us about the arrangements in place and all staff had responsibility for reporting significant or critical events. Records of those incidents were kept on the practice computer system and made available to us. We saw details of the event, steps taken, specific action required and learning outcomes and action points were noted. Other agencies were given feedback if they were involved. There was evidence that significant events were discussed at practice management team meetings and during the weekly staff meetings, to ensure learning was disseminated and implemented.

There were several examples of significant events where feedback was supplied to other agencies. For example, a discharge summary was received from hospital which stated the patient had died when they had not. This was fed back formally to the hospital so they could review their processes to ensure this did not happen in the future.

There had been a recent significant event where the vaccines refrigerator had been turned off. The vaccines were deemed unsafe to use and they had to be disposed of. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. The practice training policy set out that staff would receive child safeguarding training appropriate to their role and all staff would receive safeguarding adult training. Training records we saw confirmed staff had attended training relevant to them. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had a vulnerable children protocol in place.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. They had been trained to level three for safeguarding children to enable them to fulfil this role. The GP had previously held the role of safeguarding lead for the local area which brought additional experience in this area to the practice. As part of their role they had developed links with a

number of external organisations who had regular contact with younger people. These included counselling services, youth services and school nursing services. The practice used these links to improve the care given to young people to ensure they were giving the best care possible.

The practice had a close working relationship with the local health visiting team. Health visitors attended the monthly multi-disciplinary team (MDT) meeting at the practice to discuss children and families where there were safeguarding or other concerns. The practice also held quarterly meetings specifically to discuss safeguarding.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, patients who had been subjected to, or were deemed to be at risk of domestic violence, were flagged on the system.

The practice had a chaperone policy in place. There were no notices in the waiting room informing patients they could request a chaperone although the receptionist knew the arrangements for this when we asked. Clinical staff carried out chaperoning duties during minor surgical procedures when patients requested this service. Administrative staff who had been trained were able to act as chaperones for GP examinations if required. We saw all staff who acted as chaperones had completed training on this and had received a disclosure and barring check (DBS).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures which had been put into practice when the vaccine refrigerator had been turned off.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. The GPs did not carry medication in their bags. The practice nurse explained they had an emergency medication kit for the GPs to take out if needed. This was kept in the cupboards in the treatment room and the practice nurses were responsible to ensure the kits were stocked and the medicines were in date.

Expired and unwanted medicines were disposed of in line with waste regulations. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. Blank prescription forms were handled according to national guidelines and were kept securely.

We saw a robust system, which ensured that patients with arthritis who received repeat medication which reduces pain and swelling and required regular blood tests, were not issued with a repeat prescription until their tests were reviewed by a clinician.

The practice had a large number of patients who received their medication in dosettes (a specialist container which ensures medicines are taken at the right time, on the right day). This was identified as a high risk area for prescribing, therefore a dosette medication protocol was developed to ensure that all changes to medicines were communicated clearly from the GP via the lead receptionist to the appropriate pharmacist to help prevent prescribing errors. There were also procedures for liaison with patients, families and carers to ensure they understood any changes to their medicines.

Cleanliness and infection control

We saw the practice was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. Many patients described the practice as 'spotless'.

One of the practice nurses was the nominated infection control lead. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. There were yearly audits of infection control. The practice nurse had received specific infection control training and all other staff had completed training which included hand washing techniques and specimen handling.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation

rooms were cloth and had a note attached to them with the date they were last cleaned. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice nurses were responsible for the cleaning of their own rooms and showed us a cleaning schedule which they followed daily; there was also a schedule for a deep clean once a month. The practice had a contract with a local cleaning company for cleaning. There were similar cleaning schedules in place for use by the contracted cleaning company who cleaned the remainder of the premises.

The practice manager explained that the landlord of the building carried out the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings).

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles) and fire extinguishers.

The practice manager showed us a policy for the maintenance of the equipment in the practice. Each piece of equipment was individually listed with records of when they had been serviced or calibrated.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at were well organised and 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.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. We saw there was a rota system in place for each staff group to ensure there were enough staff on duty. The GPs had outside clinical interests other than the practice, however they all worked four days a week and they all worked on a Monday and Friday, which were the busiest days for the practice in terms of appointments, this was to ensure continuity of care. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The practice manager said when a GP was on leave or unable to attend work, a small number of locum GPs familiar with the practice were used. We saw the practice had a 'locum GP pack' in place to support locum GPs with their work. It included logistical information on the practice itself, copies of any safety alerts received recently and information on prescribing and referral processes within the practice.

Monitoring safety and responding to risk

The practice had comprehensive 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, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. There were health and safety checks carried out by the reception manager every month which were then signed off by the practice manager.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control lead. Each GP had responsibility for several clinical areas and oversaw care in these areas.

We saw that any identified risks were discussed at GP meetings and within team meetings. The GPs checked the patient notes of every patient who had not attended a chronic disease appointment to ensure that further appropriate protective steps could be taken to contact the patients if they were thought to be vulnerable, this resulted in more patients attending their appointments.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies. For example, all staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR).

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were

trained to use it. They also showed us the emergency medicines which were available in a secure area of the practice, all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been updated regularly and contained relevant contact details for staff to refer to, for example who to contact if the heating system failed.

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

Outstanding ☆

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 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 practice had a GP-led diabetic clinic and all patients with diabetes were reviewed every six months. The Practice led on the care of over 90% of its diabetic patients, rather than referring them to secondary care. The lead GP met with one of the diabetes consultants and diabetes specialist nurses from the local Foundation Trust in September 2014 to share and discuss the practice systems for diabetes care and the management of complex patients.

There were care plans in place for 2% of the practice population with complex needs to help avoid unplanned admissions into hospital. These plans were reviewed every three months with the community matron. All of these patients had special notes in place with the out of hour's provider so they were aware of their needs. The practice ensured housebound patients with chronic disease or who were elderly or frail were assessed by offering a pro-active annual visit by one of the nursing team. All patients aged over 75 had a named GP.

The practice had developed care plans for all patients who had dementia. The practice had recently carried out an audit of patients using the Dementia Toolkit to help to identify patients with the condition and to validate the register they held.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored very well on clinical indicators within the QOF. They achieved 99.8%, which was above the average in England of 96.47%.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who completed CQC comment cards.

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

The practice had an organised system in place for completing clinical audit cycles. We saw several examples of two audits which had been carried out and the practice could demonstrate that they had improved outcomes for patients over time.

The audits and quality improvement activities which were carried out were over and above those which were required to achieve targets such as QOF. For example, the practice were aware that 20% of the deaths of patients registered at the practice, in a recent year, were either related to drugs, alcohol or violence. Patient deaths were discussed at practice meetings and an audit was commissioned which showed that the coroner does not automatically inform the practice of the cause of death. The practice were trying to have this policy reviewed in order that they could take away any learning to improve care, from the death of the patient.

The practice had carried out an audit of the quality and safety of the prescribing of medication using a set of Royal College of General Practitioners (RGCP) indicators. The practice learned it was performing well in this area although it identified specific patients, mostly those using warfarin and antibiotics, who required a review. The patients were allocated to specific clinicians for this to be carried out.

The practice had recently been successful in receiving funding from the local clinical commissioning group (CCG) to set up clinics to develop pathways for patients with chronic diseases for which they do not have a target to achieve. The practice felt that these types of diseases such as coeliac disease were given a low priority and they wanted to integrate the care of patients affected by them into their current clinics.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

There was a dedicated service for substance misuse. The practice held two clinics a week for patients with substance misuse problems. They worked closely and discussed the care of patients with the local substance misuse team who were based at the practice on clinic days.

The lead GP had a clinical interest in the area of substance misuse; they were a research associate at a local university. Their research had been subjected to research ethics approval and published in peer reviewed journals. Subjects in this area included motivation to change, brief interventions and the use of screening tools. They had undertaken training in cognitive behaviour therapy (CBT).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a training policy which set out the objective and aims of training and what courses were mandatory. We reviewed staff training records which were comprehensive and saw that staff were up-to-date with attending basic courses such as fire safety. Every member of staff in the practice had an individual training plan which set out which training had been completed and when it was next due. All GPs were up-to-date with their yearly continuing professional development requirements.

The practice was a training practice, three of the GP partners were GP trainers and they told us they consistently received positive feedback on the quality and level of supervision and the involvement of the whole team in their training from the GP student registrars who worked with them. We spoke with a GP registrar who told us they received tutorials from all three GP trainers, there were arrangements in place for the monitoring of performance and they received clinical supervision which was available daily in protected time.

All staff undertook annual appraisals. These identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, we spoke with a practice nurse who had joined the practice in the last six months. They told us they had been supported well by the practice and the senior nursing staff and training was provided on a regular basis. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties.

Staff received 360 degree feedback every year as part of the appraisal process. 360 degree feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. All staff received this from the practice manager and the practice manager received their feedback from the lead GP. Staff told us this was a good way to improve their performance and welcomed this approach as promoting an open and honest culture in which learning took place.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. A pack had also been developed to support locum GPs with their work.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice could demonstrate that they worked closely with other services to deliver effective care and treatment across the different patient population groups. For example, they worked closely with the substance misuse team who were based at the practice two day per week.

The practice held multidisciplinary team meetings every month to discuss the needs of high risk and vulnerable patients, for example, those experiencing poor mental

health. These meetings were attended by the practice's GPs and nurses along with district nurses, community psychiatric nurses, drug and alcohol workers and palliative care nurses. The practice felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information.

The practice had an action plan which set out dates of engagement meetings with CCG, for example, when practice staff were attending locality meetings during the year.

Blood results, x-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had recently reviewed the way in which letters were dealt with. A new system had been developed whereby administration staff checked the letters and then gave them to the GP who led on the patient's care. There were arrangements in place to ensure any necessary actions were taken if that GP was not at work that day. It was felt that this had streamlined practice and provided the patient with greater continuity of care. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent. We also saw a consent to treatment form which the practice used for consent to investigations or specific treatment.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

The practice used every opportunity to promote healthy living. Staff attended monthly health meetings at the local community centre with other community partners to look specifically at the health of local people. We saw minutes of these meetings. Agenda items included the development of a fitness project led by the practice in partnership with a local sports club. Running sessions were held every week. Other agenda items included the discussion of local health data, the practice's patient forum and new projects such as working with schools in relation to health and wellbeing.

It was practice policy to offer all new patients a health check. New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, post or hand into the reception team. The healthcare assistant carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice offered a full range of clinics; these included counselling, contraceptive services, smoking cessation and management of long term conditions. There was information on the practice website regarding travel and flu vaccination requirements. NHS health checks were offered for patients aged 40 -74.

The practice offered regular baby clinics which are multi-disciplinary involving the health visitor, practice nurse and a GP; immunisations were available for all children every week both in the baby clinic and at other times for older children. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey, data was above all of the national averages. For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 97%, compared to the national average of 85%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 94%, the national average was 85%. Patients who said the practice nurses were good at treating them with care and concern was 98%, the national average was 90%.

We reviewed 47 CQC comment cards completed by patients prior to the inspection. Comments were overwhelmingly positive. Common words used by patients included “excellent”, “helpful” and “professional”. Several patients commented on the high quality of the care they received.

We spoke with five patients on the day of our inspection. All of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. Patients commented that they thought they received a very good, high quality service from the practice.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. Some of the reception staff had received customer care training. The practice had a customer care protocol which covered the ‘golden rules’ of customer care for example smiling, saying hello and being polite.

The reception area was set away from the waiting area in the surgery which helped to maintain privacy at the reception desk. Phone calls from patients were taken by staff in areas where confidentiality could be maintained.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2014 National GP Patient Survey, 94% of patients said the GP they visited had been ‘good’ at involving them in decisions about their care (national average was 81%). The data showed that 94% of patients said the practice nurse they visited had been ‘good’ at involving them in decisions about their care (national average 85%)

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service, either in person or by telephone.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive. Patients also commented they felt staff regularly went beyond the call of duty and exceeded their expectations. For example, when supporting patients and helping them to cope with long term health problems.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. This included MIND for help with mental health issues and the Macmillan service for support following bereavement.

The practice had a register of carers. Carers known to the practice were coded on the computer system so they could be identified and offered support. The practice manager

Outstanding ☆

Are services caring?

was the lead on 'carers' for practices in the local area. They had carried out research with the local carers organisation which included looking at the referral process for carers to a support group. The practice clinical commissioning action plan included an area with tasks in relation to the improvement of service to carers, for example, staff had received carers training in October 2014 and carers between the age of 40 and 74 were offered a health check.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance when appropriate. The practice manager said this would be the GP who had been involved with the patient and their family in order to maintain continuity of care. Staff were kept aware of patients and families who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Three of the GP partners and many of the staff had worked there for many years which enabled good continuity of care. The practice had close links with the local community through the different multi-disciplinary meetings and groups the practice attended.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. For example, the practice had identified its highest risk patients and had developed holistic care plans to meet their needs. This included patients who were housebound and those who lived in local care homes. Patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. Where possible the practice completed reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions. Longer appointments were available for people who needed them.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a patient participation group (PPG) and had recently been successful in increasing the numbers of patients involved in the group from 18 to 79. The practice had implemented suggestions for improvements and made changes to the way it delivered services following feedback from the group. A suggestion was made for the meetings of the PPG to be held in the local community centre which the practice then arranged.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone translation services if required, for those patients whose first language was not English.

The practice had a relatively high population of patients with learning disabilities as there was a residential home for people with learning disabilities located within the practice's boundary. The patients were offered an NHS health check which involved appointments with a lead GP and practice nurse for 20 minutes each. The lead GP had also validated the learning disabilities register in the last year to ensure that all patients with a learning disability were included in this service.

The practice worked closely with mental health services and provided a room for a cognitive behavioural therapy (CBT) mental health worker, weekly, as well as a counsellor from MIND (MIND is a mental health charity).

The premises had been designed to meet the needs of people with disabilities. All of the treatment and consulting rooms could be accessed by those with mobility difficulties and the front door opened automatically. The patient toilet could be accessed by patients with disabilities and there were designated disabled parking spaces in the main surgery car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP if they had a preference.

Access to the service

Patients we spoke with and comments cards indicated that it was easy to obtain an appointment and patients said that they felt they were lucky to have a practice who could provide this service. Some patients told us they had changed practices to Teams Medical Practice for this reason; the practice had a good reputation in relation to patients being able to obtain an appointment. This was reflected in the data from the national GP survey. 92% of patients reported a good overall experience of making an appointment (national average 78%). Whilst speaking to patients in the waiting room we observed that they did not have a long wait to be seen by the GP or practice nurse, appointments were running to time.

The practice had an access protocol which set out how staff were to respond to demand, how it was monitored and that an annual patient survey would always be carried out regarding access. The recent survey on patient access carried out in 2013/14 resulted in the introduction of on-line booking facilities. A text reminder service was also to be introduced to remind patients of their appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were offered Monday to Friday from 8.00am until 6.00pm. Medical emergencies were seen on the day. Appointments could be booked up to four weeks in advance. We asked when the next routine appointments were for two of the GPs and saw appointments were available within the following two days. Data from the national GP survey showed 93% of patients said it was easy to get through on the telephone (national average 75%) The practice had a policy that the phone should be picked up by staff by the sixth ring. 91% of patients reported being very satisfied or fairly satisfied with their GP practice opening hours. (National average 79%).

Comprehensive information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. 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 practice offered appointments and repeat prescriptions on-line. Repeat prescriptions could also be ordered via an automated telephone line which was available 24 hours a day.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was included in the patient information leaflet.

The practice manager supplied us with a schedule of seven complaints which had been received in the last 12 months and we found these had all been dealt with in a satisfactory manner.

Are services well-led?

Outstanding ☆

(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. This was documented within the practice's statement of purpose. It stated the practice's aims and objectives included

- To provide high quality, evidence based care to the practice population by implementing evidence-based guidelines for the treatment of chronic disease.
- To improve access to practice based services by increased utilisation of the skills of the practice nursing team.
- To work in collaboration with other health and social care services to deliver improved health outcomes for the local population'.

It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

The lead GP and practice manager told us that the practice had a culture of continuous improvement. They told us that the service the practice provided had taken over 20 years to build up and they had repeatedly looked at innovative ways to drive forward the business.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

The practice had a clinical commissioning action plan. This was developed in conjunction with the clinical commissioning group (CCG). The action plan included improving quality, for example, ensuring the stroke disease register was up to date by searching for those who were at risk of stroke and not coded correctly; and providing reviews to those patients. There was a section of the action plan where the practice could choose its own area to review, the practice chose veterans, a veterans champion had been identified and the practice aimed to increase the number of veterans on their register and for staff to receive veterans awareness training.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

The practice held regular governance meetings where matters such as performance, quality and risks were discussed. There was a timetabled schedule of meetings for the forthcoming year. Practice meetings with the whole team were held every month. Administration staff attended meetings weekly, the practice nurses and healthcare assistant held meetings every month. There were clinical meetings and a partners and practice managers business meeting every other week. Multi-disciplinary meetings were held monthly. This helped to ensure that information was shared at the appropriate levels and in a timely manner.

The practice had comprehensive assurance systems and performance measures, which were reported and monitored. These included the use of their electronic patient records system. The QOF data for this practice showed it was performing above the averages of the local CCG and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. The practice had identified clinical leads for many of the QOF areas, for example diabetes or epilepsy, had clinical leads allocated to them. We saw that QOF data was regularly discussed at team meetings. Lead GPs had also been identified for many of the additional and enhanced services the practice provided.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems and identify where action was needed. The practice had completed a number of clinical audits throughout 2014, for example in relation to coding of renal anaemia, a review of patients who were regularly prescribed laxative and an audit of patients with dual diagnosis of asthma and COPD. The results of these audits demonstrated outcomes for patients had improved. The practice had also carried out audits which were not target driven, for example, in relation to coeliac disease.

There were comprehensive arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed frequently at all levels across the practice.

Are services well-led?

Outstanding ☆

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

The practice manager and GPs told us forward planning was discussed regularly. The practice had plans to recruit a GP with an interest in substance misuse who would assist with service provided to patients with these problems.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there were lead GPs in areas such as safeguarding and lead nurses for the management of specific long term conditions such as heart disease and chronic kidney disease. We spoke with staff throughout the practice, both clinical and non-clinical; they were all clear about their own roles and responsibilities. They also knew who the nominated leads were across the practice. We found there were high levels of staff satisfaction. Staff were openly proud of the organisation as a place to work, spoke highly of the open and honest culture and welcomed the system of 360 degree feedback which was included in the appraisal process. There were consistently high levels of staff engagement.

Staff we spoke with and records we saw showed that staff meetings were held regularly. Staff said they felt actively encouraged to raise any concerns and suggestions for improvement they had.

We spoke with two visiting healthcare professionals on the day of our inspection who told us the practice was proactive in their approach to the care of patients. They said staff listened, and were keen to be involved. Staff were organised, there was no hierarchy and they had regular meetings which were not rushed. Feedback from patients about the practice was always positive and patients told them the practice was so sought after their relatives wanted to register there.

We found the practice leadership promoted continuous improvement at all levels and staff were accountable for delivering this. There was a clear approach to seeking out and embedding new ways of providing care and treatment. For example, the practice had recently reviewed the procedure for letters which were received into the practice. Rather than the letters being given to the on call GP they were checked by the administrative staff and given to the GP who leads the patients care. This helped to streamline the process and provided the patient with greater continuity of care.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. The practice manager told us staff had access to all of the practice's policies online. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from staff through staff meetings, appraisals, 360 degree feedback and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a patient participation group (PPG) which the practice had worked hard recently to increase the membership of. At the time of the inspection there were 79 members. The practice worked together with the group to produce a survey which looked at whether patients felt informed about using modern technology to assist with the access to the practice's services. 100 patients completed the survey. As a result of the survey the practice introduced the booking of patient appointments on-line and a text message service to remind patients about their appointments.

Other changes which the practice had carried out as a result of suggestions from the PPG were to remove the suggestion box from being close to the reception area to a place where staff could not see who was posting suggestions. Posters were displayed in all of the clinical rooms where patients attended appointments promoting the PPG and asking patients to join in order to improve services further.

The practice had used social media to engage with younger patients. This included the introduction of a Facebook page and twitter account, which was regularly updated. This was used to obtain further feedback on their services and to promote the patient participation group. There was

Are services well-led?

Outstanding ☆

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

also health promotion information shared on the social media sites by the practice. At the time of our inspection the Facebook page had received 86 likes and two five out of five star reviews. The Twitter account had 33 followers.

Feedback from patients was encouraged and we saw the practice shared this feedback regularly with staff. This included when there were lessons to learn from patients who had raised complaints or concerns and also when patients had complemented the practice and the staff who worked there.

The practice had a regular newsletter. This was available in the surgery but patients could also sign up on-line and receive it via email. The newsletter contained information regarding services, it also promoted the patient forum and asked for veterans to let the practice know who they were so that they could offer them referral to other services.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff we spoke with said the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included a personal development plan and 360 degree feedback. Staff told us that the practice was very supportive of training and development opportunities. For example, we spoke with a nurse who had joined the practice in the last six months. They told us they had been supported well by the practice and the senior nursing staff since joining the practice. They said updates to training on immunisations and cervical screening had already been provided and they knew further training was planned.

The practice had completed thorough reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. There was evidence that feedback from significant events was supplied to other agencies to help improve learning. Staff we spoke with consistently referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients. The practice manager said incident reporting was encouraged within a 'no blame culture', and was seen as a learning event and opportunity to improve by all of the practice management.

The GP partners all had outside clinical interests in primary care which brought experience to the practice, for example, the lead GP was a research associate at a local university.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice. The Foundation Trust met with the practice to share and discuss the practice systems for diabetes care and the management of complex patients.