The Westgate Practice

Quality Report

Greenhill Health Centre
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Date of inspection visit: 16 February 2015
Date of publication: 22/10/2015

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 16 February 2015 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment, but not necessarily with their preferred GP, and urgent appointments were available the same day either with a GP or the advanced nurse practitioners.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

There were some elements of outstanding practice within the population group for working age people;

- Appointments with a phlebotomist were available at times suitable for patients who commuted to work.
- In-house physiotherapist services were available for patients to help patients recover from injuries.
- The Westgate Practice was the first practice in the area to launch a virtual Patient Participation Group (PPG), allowing patients to contribute ideas and suggestions as to how services may be improved.
- The practice held evening health promotion events to provide information and advice to patients in relation to maintaining good health and disease prevention.
- The practice offered an extensive range of online services

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

The provider should:

- Ensure all required recruitment checks are kept in the relevant staff file.
- Strengthen the infection prevention and control processes.
- Include information on sibling's records of children identified as at risk / vulnerable.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Data showed patient outcomes were above average for the locality. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Appraisals and individual personal development plans were in place for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the locality for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. They had a system for recording patients preferences for example; a request for a female GP or their named GP. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Vulnerable patients could have extensive assessments in their own home.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice. They confirmed that they were usually offered a same day appointment when they telephoned, and could also book appointments in advance. The practice offered extended hours two morning and two evenings a week. Phlebotomy appointments were provided at times suitable for patients who commuted to work and may be unable to access

Summary of findings

these services during normal working hours. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. They offered an in-house physiotherapist whose aim was to respond to acute injuries and keep people at work. Appointments for this service could be made without the need to see a doctor. There were a range of clinics to provide help and support for patients with long-term conditions. The practice was proactive in offering online services which were beyond their contractual obligations, as well as a full range of health promotion and screening services. For example they held health promotion events in the evenings with invited speakers and service providers.

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear management and leadership structure which was fit for purpose and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice was an advanced training practice and had pioneered training schemes, for example physicians' assistants in general practice. They had a long term commitment to training with experience and involvement at all levels. The practice described it as an essential element of their training and mentoring.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice 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. Influenza and shingles vaccinations were offered to older patients according to national guidance.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. 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 and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours two mornings and two evenings a week.

There were some elements of outstanding practice which included phlebotomy appointments aimed for their commuter patients and an in house physiotherapist whose aim was to respond to acute injuries and help keep people at work. Appointments for this service could be made without the need to see a doctor. The practice was proactive in offering online services which were beyond their contractual obligations, as well as a full range of health promotion and screening services that reflected the needs of this age group. For example they held health promotion events in the evenings with invited speakers and service providers. The practice was the first to launch a virtual Patient Participation Group (PPG) and on the date of inspection had 313 members.

The practice offered all patients aged 40 to 75 years old a health check with the nursing team. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence, including young people in temporary accommodation and people living at a local refuge. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

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

could refer patients directly to the mental health crisis team or community mental health team. The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place. Information about how to access mental health services was available in the waiting areas.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection. Patients were very satisfied with the service they received at the practice. They told us they could get an appointment at a time that suited them, including same day appointments. However, they did comment that they could not always get an appointment with their preferred GP. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed 26 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of these were very positive about the service experienced. Patients said they felt the practice offered an excellent service, and staff were considerate, helpful and caring. Three patients made comments that were less positive but there were no common themes in these.

We looked at the national GP Patient Survey published in January 2015. The survey found that 93% of patients rated The Westgate Practice as good or very good, which placed them amongst the best practices. The results showed that 85% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

- Ensure proof of identification is checked at recruitment and kept in the relevant staff file.
- Strengthen the infection prevention and control processes.
- Include information on sibling's records of children identified as at risk / vulnerable.

Outstanding practice

There were some elements of outstanding practice within the population group for working age people;

- Appointments with a phlebotomist were available at times suitable for patients who commuted to work.
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- The Westgate Practice was the first practice in the area to launch a virtual Patient Participation Group (PPG), allowing patients to contribute ideas and suggestions as to how services may be improved.
- The practice held evening health promotion events to provide information and advice to patients in relation to maintaining good health and disease prevention.
- The practice offered an extensive range of online services.

The Westgate Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Westgate Practice

Westgate Practice is located in Greenhill Medical Centre, close to Lichfield City Centre. The practice provides services to people who live in Lichfield and a number of surrounding villages.

The practice has nine GP partners (six male and three female), three salaried GPs (all female), three nurse practitioners, eight practice nurses, two health care assistants, and a practice management team. There are 20356 patients registered with the practice. The practice is open from 8am until 6.30pm Monday to Friday. The practice offers extended hours on Mondays and Wednesdays. Additional appointments are available on these days from 7am until 8am, and 6.30pm until 8pm. The practice treats patients of all ages and provides a range of medical services. Over 30% of the practice population is aged 65 years and over.

The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice also participates in the training of student doctors from two local universities.

The Westgate Practice also has a branch practice (known as Shenstone Surgery) in Shenstone, Lichfield. Patients registered with the practice may visit either location to receive services. We did not visit the branch practice as part of this inspection.

The Westgate Practice has a contract to provide General Medical Services.

The Westgate Practice has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by Staffordshire Doctors Urgent Care via NHS 111.

Why we carried out this inspection

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

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

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.

Detailed findings

How we carried out this inspection

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

We carried out an announced visit on 16 February 2015. During our inspection we spoke with four GPs, a registrar, an advanced nurse practitioner, the practice nurse manager, the general manager, the office manager, the Human Resources and Patient Services Manager and two reception/administration staff. We spoke with five patients who used the service about their experiences of the care they received. We reviewed 26 patient comment cards sharing their views and experiences of the practice. We also spoke with staff from two local care homes.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred over a number of years and we were able to review these. Significant events were a standing item on the practice meeting agenda and were reviewed quarterly. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the Patient Services Officer. They told us about the system used to manage and monitor incidents. We saw that incidents were discussed and evidence of action taken as a result. For example, a patient received a reminder for a national screening programme whilst they were undergoing treatment for a related condition. As a consequence, letters received with a specific diagnosis were managed by the relevant administrator and the appropriate registration department was informed so reminder letters were not sent out. Staff told us where patients had been affected by something that had gone wrong, and in line with practice policy they were given an apology and informed of the actions taken.

There was a policy in place for managing national patient safety alerts. These were disseminated by email to the relevant practice staff to action. All alerts were stored electronically, which provided access to all staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible around the practice including in each consulting room.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children who could demonstrate that they had the necessary training to enable them to fulfil this role. Staff were aware of which GP was the safeguarding lead. They told us that if the lead GP was not available, they could go to the duty GP or their line manager. Nursing staff were able to describe circumstances when they had raised safeguarding concerns with the GP lead, who had then taken appropriate action.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS Web, which collated all communications about a patient including electronic and scanned copies of communications from hospitals. The practice had only recently started to use EMIS Web and the system was not yet being used to its full potential.

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). Information about the chaperone service was included on the practice website and in the practice booklet. Nursing and administrative staff acted as chaperones. Staff had received appropriate training and understood their responsibilities when acting as chaperones, including where to stand to be able to

observe the examination and what to do if they had any concerns regarding the examination. One patient spoken with on the day of the inspection told us that chaperones were available.

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities. However, staff did not record information electronically for all siblings of a child / children with protection plans when they did not have a plan in place themselves. There was a system in place that highlighted patients with caring responsibilities. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they cared for. To do this, carers were offered additional health checks.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us they had a very good working relationship with the health visitor attached to the practice. Weekly child health clinics were held at the practice, and provided an opportunity to discuss any concerns regarding children. The health visitors were located in the same building which provided the opportunity to discuss any concerns as they arose, for example, a child not attending for their immunisations.

Medicines management

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

Processes were in place to check medicines were up to date and suitable for use. Records demonstrated that all medicines used in the practice were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines kept in the nurses' room. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. We saw evidence that nurses and health care assistants had received appropriate training to administer vaccines. Three members of nursing staff were qualified as independent prescribers. They received regular supervision and support in their role from the lead GP for medicines management. They also completed a competency framework for prescribers annually as part of their appraisal.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy, and we observed this to be the case. The landlord of the building was responsible for the cleanliness of the building. We saw that there were cleaning schedules in place.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All nursing staff received training about infection control specific to their role. This training was updated annually. The records showed that this training was overdue but had been booked for July 2015. We saw that infection control updates had been discussed in the sisters' meeting in January 2015. Infection control audits had not been carried out.

Good

Are services safe?

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

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The landlord of the building was responsible for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed a risk assessment had been carried out, and appropriate action taken to reduce the risk of infection to staff and patients.

Equipment

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

Staffing and recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. We looked at the records for two newly appointed members of staff. We noted that although all of the recruitment checks had been undertaken prior to employment, proof of identification was not held in staff records. All the records that were checked contained and where appropriate confirmation of professional qualifications. Proof of checks through the Disclosure and Barring Service (DBS) were kept in an electronic password protected file. Photo identification was checked and held of file by the Data Quality Officer, as part of the induction process when new staff applied for the smart card access. The practice had carried out risk assessments on the different staff groups to assess which staff needed to have a DBS check in place.

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 from the minutes of the partners meetings that each time there was a staff vacancy; the needs of the service were reviewed. Staff told us that there was a minimum number of staff on the rota each day. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us that holiday cover had been built into the staffing levels, although staff were flexible and would work additional hours if required.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice also had a health and safety policy.

The landlord of the building was responsible for maintaining the building. A number of risk assessments were seen, for example, fire and legionella risk assessments. Risk assessments of the building were not kept on site. The practice had carried out its own risk assessments, for example visual display users and work station assessments. We saw individual risk assessments were also carried out, for example on a member of staff who was pregnant.

Staffing establishments were reviewed to keep patients safe and meet their needs. Minimum staffing levels had been established and rotas were in place to maintain these levels. A lone worker policy was in place to cover occasions when staff worked on their own, for example at the branch surgery and the medical secretaries, who worked in a separate building.

Good

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice was part of a project to provide a comprehensive medical review of those patients most at risk of an unplanned admission. The practice worked closely with clinical nurse specialists and the community intervention team, as well as the community matrons and district nurses to provide support to older patients and those with long term conditions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Nursing staff also received training on anaphylaxis (severe allergic reaction). Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. For example, contact details of the utilities company if any utility failed. The business continuity plan was available in paper copy, stored electronically on the computer system, and also off site.

The landlord of the building had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the system was tested weekly and serviced on a regular basis. Practice records showed that staff were up to date with fire training and that they had attended a fire drill during 2014.

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. The practice nurse we spoke with told us that new guidance was emailed from the GPs and any changes discussed at the sisters' meetings. We saw on the agenda of the sisters' meetings that protocols were discussed.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The practice nurse manager told us they were made aware of any new best practice guidelines for the management of specific conditions. Our review of the sisters' meeting minutes confirmed that this happened and new protocols were discussed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF is an incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 88% QOF points out a possible 100%, which was lower than the national average. However, the practice told us they did not 'exception report', so any patients who choose not to take the recommended medication or attend an annual review were not discounted from the numbers. As a consequence the practice did not meet all the required standards for QOF in diabetes.

The GPs and the practice nurses supported patients with long term conditions and chronic disease management. Patients were identified on the electronic system and invited for an annual review of their condition. Staff told us that self-management plans were developed with the patients and these were reviewed during the annual review. The practice had recognised that they were below the national prevalence for QOF in asthma and chronic lung disease due to the practice demographics. As a consequence they had worked with the community respiratory nurse specialist, who reviewed the patients to ensure the correct treatment plan was in place, and invited patients for reviews every six months.

The practice offered all aspects of the Avoiding Unplanned Admissions enhanced service. This is where the practice identified the most vulnerable patients and developed care plans to assist with avoiding admission to hospital. These care plans were reviewed every quarter. Discharge letters were analysed and patients contacted within three days of discharge to ensure the correct medication and services were in place.

The practice had a system in place for completing clinical audit cycles. The practice showed us a number of clinical audits undertaken in recent years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to reduce blood cholesterol levels a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine in combination with a particular hypertensive (high blood pressure) medicine were not put at risk of serious medicine interactions. The first audit demonstrated that 111 patients were not receiving the revised dose. The information was shared with GPs, who were asked to adjust dosages during medication reviews. A second clinical audit was completed one year later which demonstrated that 69 patient were not receiving the new recommended dose. A review of their notes included that some patients had been prescribed the dosage by a consultant, although for some patients there was no clear rationale in their notes. The practice planned to repeat the audit in 12 months' time. Other examples included audits on the prescribing of medicines for high blood pressure and antibiotic prescribing by the advanced nurse practitioners.

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. The GPs told us that in order to maximise the effectiveness of the medicine review appointment, appropriate blood tests were completed prior the appointment. The practice was supported by the

Good

Are services effective?

(for example, treatment is effective)

medicines management team from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. The information was then passed on to the lead GP for medicines for them to action.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with each GP taking a lead in various aspects of medicine at the practice, including family planning. All GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There was protected learning time each month, with each section of staff attending training relevant to their role. The advanced nurse practitioners also attended a monthly tutorial with two of the GP partners. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

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 smoking cessation. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma and diabetes were able to demonstrate that they had appropriate training to fulfil these roles. The advanced nurse practitioners were independent prescribers of medicines and were supervised by one of the GP partners.

Staff described how poor performance was managed when identified and appropriate action taken to manage this.

Working with colleagues and other services

Blood results, X-ray results, letters from the local hospital including discharge summaries, information from out of hours providers and the 111 service were received either electronically or as a paper copy. Information from other services about patients was reviewed each day by the GPs on duty. Each GP was responsible for the action required. The practice used an electronic system for document management. This system enabled documents to be scanned onto the electronic system and then allocated to the appropriate clinician. Required actions were recorded on the electronic system and passed on to the relevant person to action. We saw that the system to review incoming information and manage tasks, pathology reports and documents was effective.

The practice held multidisciplinary team meetings to discuss patients on the palliative care register. These meetings were attended by district nurses, the hospice care team and the GPs. The GPs told us that the meetings were minuted, and patient notes updated during the meetings. All patients identified as having end of life needs were discussed and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice monitored their referral rates for outpatients and compared these against the average for the local Clinical Commissioning Group. The data showed that the practice had a lower than average referral rate for outpatient referrals. The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. Staff told us that they monitored these referrals and contacted patients if they had not made an appointment with a number of months.

The practice had systems to provide staff with the information they needed. The practice had recently started to use the electronic patient record EMISWeb to coordinate, document and manage patients' care. All staff had been

Good

Are services effective?

(for example, treatment is effective)

trained on the system and continued to receive support the EMISWeb support team. 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 saw that the practice had policies on consent, the Mental Capacity Act 2005, and the assessment of Gillick competency of children and young adults. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

Training on the Mental Capacity Act 2005 for the GPs had been arranged for February 2015, and was being arranged for nursing staff. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Staff spoken with told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment. The GPs spoken with described a situation where a mental capacity assessment had been used and appropriate action taken in the patient's best interest as a consequence.

Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt resuscitation' care plans. They told us the appropriate paperwork was completed and scanned on to the electronic system. The staff representative from one of the care homes told us that GPs discussed all of the 'do not attempt resuscitation' care plans with the patient and their families. There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The member of staff concerned received additional training for this role and was working through a workbook of competencies for health checks. We noted a culture amongst the practice to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were invited by letter to attend for a health check. Information relating to this was included on the practice website. Patients had a blood test prior to their health check and staff told us having evening clinics for phlebotomy had encouraged patients to attend.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included travel advice and vaccinations, smoking cessation and referral to the Waistlines programme. The practice had organised separate Women's and Men's Health evenings during 2014 and further evenings were planned during 2015. The practice invited speakers and other agencies to these evenings to raise awareness, for example breast awareness, domestic abuse, waistlines and counselling. The practice produced a quarterly newsletter, which also contained health promotion information. This was available on the practice website, electronically and in paper form at the practice. The practice made good use of notice boards at the practice to promote awareness of campaigns, for example flu immunisations and breast screening. A range of leaflets were available for patients at reception and in the waiting areas.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the local Clinical Commissioning Group and there was a clear policy for following up non-attenders. The shingles vaccine was offered according to national guidance for older people.

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, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from these sources showed patients were satisfied with how they were treated and that this was with care and concern. For example, data from the national patient survey showed that 93% of patients rated their overall experience of the practice as good or very good, which was above the Clinical Commissioning Group (CCG) area average. The survey showed that 92% of patients felt that the doctor was good at listening to them, with a score of 93% for the nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards, the majority of which were very positive about the service experienced. Patients said they felt the practice offered an excellent service, and staff were considerate, helpful and caring. One patient commented about a particular GP. They commented that the GP always took the time to listen and went the extra mile to ensure the patient's physical and mental wellbeing. Another patient commented that they never felt that they weren't being listened to. Three patients made comments that were less positive but there were no common themes in these. We spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped to keep patient information private. The seated waiting areas were away from the main reception desk, preventing conversations from being overheard. The practice had responded to concerns raised by patients about maintaining confidentiality in the waiting areas. As a consequence televisions had been installed in the two smaller waiting areas. The practice operated a system which allowed only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that the practice cared for patients whose circumstances may make them vulnerable. This included people living in care homes, in a local refuge, young people in temporary housing and people with a learning disability. Staff told us that these patients were supported to register as either permanent or temporary patients as the practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

There was information in the practice stating the practice's zero tolerance for abusive behaviour.

The practice had a programme called Westgate Gems which acknowledged staff going the extra mile and encouraged high levels of staff motivation.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff. Patients' comments on the comment cards we received were also positive and supported these views. One patient commented that they were given a thorough explanation of the diagnosis and treatment. Another patient commented that the doctors listen and respect the patient's interpretation of the symptoms.

Good

Are services caring?

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 85% of practice respondents said the nurse involved them in care decisions and 88% felt the nurse was good at explaining treatment and results. The results from the patient satisfaction questionnaires sent out to patients by each of the practice's partners showed that over 90% of patients said they were sufficiently involved in making decisions about their care.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us they did not have access to a translation service, and asked patients to bring a family member who spoke English to support them. Clinical staff were aware of the challenges around families translating for patients. They told us they also used electronic systems to translate written information.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, long term conditions, those with a learning disability or mental health difficulties, and those requiring end of life care. Individual care plans had been developed for these patients. Multi-disciplinary meetings between GPs, palliative care nurses and district nurses were held monthly to review care plans for patients near the end of their life. The GPs told us that they updated patients' records during the meeting, to ensure that all relevant information was recorded. The practice used special notes to ensure that the out of hours service was also aware of the needs of these patients when the practice was closed. We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma. Individual preferences and needs were reflected in how care was delivered. They had a system for recording patients preferences for example; a request for a female GP or their named GP.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 88% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern with a score of 89% for nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Leaflets in the patient waiting rooms and information in the practice booklet and on the website told people how to access a number of support groups and organisations. Patients could also be referred to local carer support groups and post natal support groups. The practice's computer system alerted staff if a patient was also a carer. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. To do this, carers were offered additional health checks.

The Citizen's Advice Bureau (CAB) held weekly sessions at the practice. The CAB assisted patients to access benefits and support that they were entitled to. Patients were able to book appointments at reception or on line. From April 2015, CRUSE (a national charity) would be offering twice weekly evening bereavement counselling sessions at the practice. Although these sessions were open all local residents, patients registered at the practice would benefit as they would be seen in surroundings they were familiar with. Staff told us that patients (if they met the criteria) could be referred to a lifestyle coach to assist them physically and emotionally with their condition.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, the practice offered commuter surgeries twice a week, for patients with work commitments including appointments with a phlebotomist. The practice provided a range of services in house, for example, warfarin clinics (including dosing), near patient testing (any investigation carried out in a clinical setting for which the result is available almost immediately) and travel vaccinations. They offered an in-house physiotherapist whose aim was to respond to acute injuries and keep people at work. Appointments for this service could be made without the need to see a doctor.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. The practice was monitoring the risk of unplanned admissions and had developed individual care plans for patients. We saw that longer appointments were available if required. The practice was also reviewing the Accident and Emergency admissions of patients on the case management register to identify any changes that could be made to avoid future admissions.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Several of the GP partners were actively involved with the CCG, one as the Chairperson, and another as the Lead for Medicines Management. There was also practice nurse representation at the CCG. Two of the GPs attended the CCG locality meetings, and the business manager attended the practice manager meetings. The practice nurse told us that the CCG meetings provided the practice with an opportunity to discuss any issues and to bring back information about good practice to share with the team.

The practice actively engaged in CCG projects. For example the practice was starting a project to carry out a comprehensive medical review of the top 0.5% of patients on the case management register. This was to ensure that these patients were receiving the correct care to meet their needs.

The practice was the first to launch a virtual Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The virtual PPG was active and had 313 members with representatives from a wide cross section of the practice population. Information was shared with members electronically and members were asked to comment on any issues, surveys and proposed actions. The practice had a good working relationship with the PPG. Information about the PPG was available in the practice booklet and on the practice website.

We spoke with representatives from two local care homes. They told us they worked in partnership with the practice to meet the needs of the patients. The practice visited both care homes fortnightly to review patients who required a GP visit. Staff said that between the visits, they could telephone the practice for guidance, or to request a visit. However, the representative from one of the care homes commented that on occasions they had difficulty getting through the practice on the telephone, and sometimes reception staff were reluctant to accept the request for a visit.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice offered 10 hours a week of early and late commuter appointments for patients with work commitments. The practice provided care and support to house bound patients and patients living in a number of local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. The practice provided home visits and visited the housebound patients to provide home flu vaccinations to reduce the risk of seasonal infections, as well as a phlebotomy service. The community matron supported the practice by visiting house bound patients to ensure their medical needs were reviewed at least annually. The GPs knew the disease prevalence within the practice population and provided services accordingly. For example, clinics for long term conditions such as asthma, diabetes and chronic lung disease.

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, young people in temporary housing and patients accommodated at a local refuge. Staff told us that these

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

The majority of the practice population were English speaking patients. Staff told us that they did not have access to interpreter services and asked patients to bring an English speaking relative with them to consultations. Clinical staff were aware of the challenges around families translating for patients. Staff told us they used electronic systems to translate written information for patients. Patients could book appointments with either male or female GPs. This reduced any barriers to care and supported the equality and diversity needs of the patients.

The premises and services were suitable to meet the needs of people with disabilities. The main practice and the branch practice had been assessed as compliant with the Disability Discrimination Act 1995. The practice was situated on the ground floor of the building. There was a hearing loop system available for patients with a hearing impairment. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were automatic doors to the building, which made easy access for wheelchairs users and patients with pushchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had an equality and diversity policy in place. GPs attended equality and diversity training as a requirement for maintaining the practice's training status. The human resources manager also received equality and diversity updates as part of safer recruitment training. Other staff at the practice had not received equality and diversity training.

Access to the service

The practice booklet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments on line, via the telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. Text messaging was used to remind patients of their appointments. The system also allowed patients to reply to the text to cancel their appointment, reducing the number of non-attendees. The practice was proactive in offering online services which were beyond their contractual obligations, as well as a full range of health promotion and screening services. For example they held health promotion events in the evenings with invited speakers and service providers.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone number for the out of hours service was in the practice booklet and on the website.

The practice opened from 8am until 6.30pm. Patients could book appointments at either the main practice or the branch practice. (The branch practice closed at 1pm on a Tuesday). The practice operated a triage system each week day for patients requesting a same day appointment or home visit. The duty doctor or advanced nurse practitioner contacted the patients to assess their condition and offer appropriate advice, treatment or appointment. Patients could also request a telephone consultation with the GP where appropriate.

The practice offered a range of appointments with different types of practitioners. Pre bookable appointments were available with the GPs, registrars, practice nurses and health care assistants. On the day appointments were available with the duty GP and the advanced nurse practitioners.

Extended opening hours were also provided two days a week at the main practice. Appointments were available between 7am and 8am, and 6.30pm and 8pm on Mondays and Wednesdays. These were particularly useful to patients with work commitments. Appointments with the practice nurses and phlebotomists were also available during some of these surgeries. The practice also offered early afternoon surgeries starting at 2.30pm, enabling mothers to be seen before they collected their children from school.

Patients were generally satisfied with the appointments system. Patients told us they could get an appointment although it was more difficult to get an appointment with their preferred GP. Data from the national GP survey supported this. 92% of respondents stated that they were able to get an appointment last time they tried which was

Good

Are services responsive to people's needs?

(for example, to feedback?)

above the local Clinical Commissioning Group average. However only 35% were able to make an appointment with their preferred GP, which was below the local CCG average of 61%.

Longer appointments were also available for people who needed them and those with long-term conditions. The practice cared for patients who lived in a number of local care homes. Fortnightly visits were carried out by one of the salaried GPs to three of the care homes with the most patients. GPs visited patients in the other care homes as and when requested.

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.

Patients were made aware of how to complain through the practice booklet and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure. However, one person referred to the complaints procedure on the comment card. They commented that the complaints procedure was poor and they did not consider that their complaint had been handled well.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions were taken to resolve the complaint as far as possible. Complaints were recorded in a quarterly complaints log. We saw that these had been handled satisfactorily and discussed with the relevant member of staff and the wider staff team where appropriate. Learning from complaints was clearly recorded in the complaints log.

The practice reviewed complaints quarterly to detect themes or trends. Staff told us that during these reviews the complaints were discussed, notes taken and any learning recorded. Staff spoken with described the action they would take if they received complaints and confirmed that complaints were investigated and action plans developed, if required.

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. The aim of the practice was included in the practice leaflet and was 'to offer quality care to you and your family. The practice did not have a business plan in place to support delivery of the practice's aim, however the practices management strategy was designed and implemented with CQC inspections, changes to the GMS contract, and improvements to patient care and services, specifically in mind. The ethos of the management team was to drive and implement change to deliver high quality person centred care.

It was clear when speaking with the GPs and the practice staff that they shared this aim and were committed to providing person centred care that met the needs of the practice populations. Patients commented that they felt they received personalised care and support. Several patients commented that they felt listened to and concerns were always taken seriously.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and in paper form. Review dates were included in the policies and policies seen were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. There was an organisational structure in place for the whole practice, as well as for the nursing team. We spoke with a number of staff from different departments and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is an incentive scheme which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed that it was performing below the national average (94.2%) by obtaining 88 percentage points out a possible 100 percentage points. We saw that QOF data was regularly discussed at fortnightly partners meetings to identify actions required and remedial action where necessary. The practice was part of an opt-out local enhanced service scheme for 2013/14, which meant that published QOF results are not an accurate measure of the Practice's performance.

The practice manager told us that clinical governance was discussed at the sisters' meetings. The practice nurses had also observed each other's clinics to observe practice and maintain consistency. The nurse manager told us that the practice nurses had found this useful.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example: antibiotic prescribing, the use of diuretics and prescribing of medicines to lower blood pressure.

The practice had arrangements for identifying, recording and managing risks. The landlord of the building was responsible for maintaining the building and had carried out a number of risk assessments. The practice had also carried out its own risk assessments, for example visual display users and work station assessments. We saw individual risk assessments were also carried out, for example on a member of staff who was pregnant.

We saw that governance was discussed at a variety of meetings, including the fortnightly partners meeting. We saw from the agenda that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example one of the GP partners was the lead for safeguarding, another for medicines management and the practice nurse manager had the lead role for infection control. We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that a range of staff meetings were held, either monthly or quarterly. Minutes were timetabled for the year. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We looked at the agendas

Are services well-led?

Good

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

for the different meetings. The meetings were used to discuss a range of topics, including complaints and significant events, as well as ongoing monitoring of performance.

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

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

The practice had gathered feedback from patients through patient surveys, comments and complaints. The practice was working with the virtual Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The 2013 / 2014 patient survey focused on access to and booking of appointments, quality of care provided by nursing staff and use of the website. The survey did not highlight any issues from patients about the service they received. However, it did highlight the need for continued communication with patients about the services provided at the practice, different ways to book appointments and the extended opening hours. The results of the survey and action plan were available on the practice website.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the virtual Patient Participation Group (PPG). The practice also utilised the virtual patient group as a means of two way communication to obtain patient views about the service.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had a good working relationship with the management.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They told us that they received an annual appraisal and there was a policy in place to support this. They confirmed the practice was very supportive of training and that they had monthly protected learning time. The schedule for the whole of the year was available to staff. The practice was an advanced training practice and had pioneered training schemes, for example physicians' assistants in general practice. They had a long term commitment to training with experience and involvement at all levels. The practice described it as an essential element of their training and mentoring.

The practice was able to evidence through discussion with the GPs, staff and business manager and via documentation that there was a clear understanding among staff about safety and learning from incidents. We found that concerns, near misses, significant events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant events were received, investigated and discussed quarterly. The practice also shared 'soft information' about issues regarding secondary care with the local Clinical Commissioning Group at the locality meetings.

Several of the GP partners were responsible for the induction and overseeing of the GP registrar's training. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a GP registrar who told us there was strong leadership within the practice. They told us they felt well supported and secure in their role. They said that they were able to contribute ideas and suggest changes.

The GPs and nursing staff told us about informal daily meetings. We observed this meeting and saw good co-operative working between the clinical staff team. Staff were able to discuss any concerns or seek advice.

The practice was actively engaged with the local Clinical Commissioning Group and therefore involved in shaping local services. For example, one GP was the lead for Medicines Management at the Clinical Commissioning Board, and another GP was the Chairperson. Two of the GPs shared attendance at the locality meetings, and the

Are services well-led?

Good

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

practice nurse manager was a practice nurse representative. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted.