Lawns Medical Practice

Quality Report

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Date of inspection visit: 5 November 2014
Date of publication: 28/05/2015

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?	Outstanding
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

Our key findings were as follows:

- The practice was safe, well led, effective caring and responsive. Staff recognised and understood the needs of patients and tailored access to care and treatments to meet these needs. The practice was working in partnership with other health and social care services to deliver individualised care.
- The practice provided a safe service in an environment which was well managed and risks to staff and patients were identified and minimised.
- Staff were trained and supported to deliver high quality patient care and treatment and to improve outcomes and experiences for patients.
- The practice had analysed the needs of patients with long term cardiac and vascular conditions and had developed a scheme to deliver care to them in the most practical and convenient way for patients. The practice offered nurse led clinics for patients with conditions such as diabetes, heart failure and hypertension. These clinics were available on Mondays, Tuesdays, Wednesdays and Fridays each week and up to 16 patients were reviewed each week. The nurses liaised with GPs to review each patient's medical records and test results before appointments to determine if any changes to treatment or medicines would be appropriate. This helped to reduce the number of appointments patients needed to attend and ensured the best outcome for each patient. Late afternoon appointments were available for patients if required.

We saw areas of outstanding practice including:

- The practice understood the needs of the population groups it served and took these needs into account. Appointments for older patients and those living in the more rural areas, people who have mobility problems and others who this would benefit were offered to co-incide with the timings of the local bus services to help patients access the practice more easily.
- The practice recognised the needs of patients who were voluntary carers for others. One member of staff took the lead on overseeing the support provided to carers. In 2011 a carer's support group was set up and meetings were held at the practice. Staff invited carers to attend and guest speakers were invited to give talks

and provide advice on issues such as bereavement, power of attorney and health matters. The meetings also provided opportunities for befriending and emotional support.

- The practice had an identified member of staff who acted as a lead for supporting patients who were carers for others. In 2011 a carer's support group was set up and monthly meetings were held at the practice. All known patients who were carers were contacted and reminded of these meetings. Guest speakers were invited to give talks on a range of topics such as bereavement, power of attorney and health related matters including preventing and managing pressure sores. The meetings also provided opportunities for befriending and emotional support.
- The practice had reviewed its systems for reviewing the needs of patients with one or more long term condition and had implemented long term clinics for patients with cardiac conditions. These clinics allowed patients to attend one extended appointment for their reviews. The effectiveness of these clinics was audited and the practice reported that by combining patient reviews they had identified an additional 8% of patients who would benefit from statin medicines to reduce their blood cholesterol levels.

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 safe. Staff understood and fulfilled their responsibilities to keep patients safe and to raise and report concerns, 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 effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was used routinely in the planning and delivery of patient care and treatment. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health and self-care. Training is planned and delivered to address each staff members personal goals and to enhance the delivery of patient care. There was evidence of strong multidisciplinary working.

Are services caring?

Outstanding

The practice is rated as outstanding for caring. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care. Staff took into consideration patients emotional and wellbeing needs and planned services that supported patients and met these needs. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

We found that there were outstanding caring systems and arrangements for identifying and meeting the needs of patients, in particular older or vulnerable patients and those who had long term conditions. The Lawns Medical Practice is situated in a predominantly rural area. Appointments were arranged around the local bus timetable to help patients who relied on public transport to attend their appointments. The practice offered a monthly home delivery service for medicines to patients who were housebound and unable to visit the practice.

Summary of findings

The practice had an identified member of staff who acted as a lead for supporting patients who were carers for others. In 2011 a carer's support group was set up and monthly meetings were held at the practice. All known patients who were carers were contacted and reminded of these meetings. Guest speakers were invited to give talks on a range of topics such as bereavement, power of attorney and health related matters including preventing and managing pressure sores. The meetings also provided opportunities for befriending and emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The practice had reviewed the needs of their local population and tailored its services to meet these needs.

Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver safe, high quality outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern, monitor and improve activity. These were reviewed in order to reflect best practice. The quality and safety of services provided was monitored consistently and risks were identified and managed appropriately. Issues were addressed immediately and revisited during formal meetings. The practice was receptive to patient and staff feedback and acted upon this feedback to improve services.

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

We found that the practice provided outstanding, individualised care to meet the needs of patients who were 75 years of age and older. Home visits and telephone consultations were available where patients were unable to attend the practice. Medicines could always be delivered on a monthly basis to patients who were unable to attend the practice.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. One member of staff took the lead for supporting carers and a carer's support group was set up to provide information and practical support to patients who cared for others.

The practice had identified all their patients over 75 years of age. Each patient who was 75 years or older had a named accountable GP who was responsible for their care and treatment, in line with recent GP contract changes for 2014 to 2015.

The practice monitored the uptake rate of flu vaccinations for patients 75years and over. In order to assist patients and to maximise uptake Saturday morning appointments for flu vaccinations were held during October 2014.

The practice worked with other health care professionals such as district nursing teams and social services, and care plans were in place to support patients living at home and reduce unplanned hospital admissions.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long term conditions. We found that the practice provided individualised tailored care to meet the needs of people with one or more long term condition. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health.

The practice had reviewed its systems for reviewing the needs of patients with one or more long term condition and had implemented long term clinics for patients with cardiac conditions. These clinics allowed patients to attend one extended appointment for their reviews. The effectiveness of these clinics was audited and the practice reported that by combining patient reviews they had identified 8% of patients who would benefit from statin medicines to reduce their blood cholesterol levels. The practice had also

reduced the number of appointments patients with long-term conditions needed to attend and patients responded very positively to this. Other practices within the locality commended this initiative and were considering implementing similar systems. The practice was looking to develop this system to cover other long-term conditions.

The practice worked proactively to encourage patients between 40 and 75 years to attend for their health checks to help early diagnosis and prevention of certain health conditions such as heart disease, stroke, diabetes, kidney disease and certain types of dementia. The practice dedicated clinic appointments each week for these clinics and reported an increase in the uptake of these health checks, with on average 80 health checks carried out each quarter. An audit of the effectiveness of these clinics showed an increase in the detection of diseases including hypertension, high cholesterol and kidney disease, and appropriate treatments were commenced for these patients, thereby demonstrating a proactive and effective approach to identifying and managing the long-term health conditions of patients.

One of the GP's at the practice held monthly outreach clinics for people with diabetes and one of the nurses provided a home visit service for patients who were unable to attend the clinic.

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Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person, by telephone or via the practice website. Appointments could be booked up to six weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access to midwife clinics every week. The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Appointments for childhood immunisations were available at times to suit patients.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. Appointments could be booked in person, by telephone or via the practice website. Appointments could be booked up to six weeks in advance. GP appointments were available up to 7pm and appointments for blood tests with health care assistants available from 8 am on Mondays, Wednesdays and Fridays and from 7.30 am on Tuesdays and Thursdays.

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Two afternoon clinics were provided each week for patient health checks. The practice provided travel vaccination clinics with a practice nurse. Information on the various vaccinations available including diphtheria, tetanus, polio, and hepatitis A was available on the practice website.

When patients required referral to specialist services they were offered a choice of services, locations and dates.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice was well established within the community and knew their patient group well. The practice kept a register of patients with learning disabilities. We saw that 48 patients were recorded on the register. One member of the receptionist's team took the lead in coordinating and arranging annual health checks.

The practice regularly 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.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good 

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check.

The practice had a lead GP for overseeing the treatment of patients who experienced poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients with substance or alcohol misuse were referred to the local recovery, rehabilitation and support services.

Summary of findings

What people who use the service say

Patients who we spoke with on the day of our inspection and those who completed comment cards prior to our visit made very positive comments about Lawns Medical Practice. They told us that they were very happy with the care and treatment that they received. 33 patients completed comment cards and the majority of these indicated that staff were caring and respectful. Patients told us that they felt listened to and that staff responded to their needs in a timely way.

Patients told us that they were very happy with the care and treatment that they received. They told us that they were able to make same day appointments of to pre-book in advance. The majority of patients said that they could always be seen by the GP of their choosing. Some patients comment that this sometimes meant waiting for an appointment.

Outstanding practice

- The practice understood the needs of the population groups it served and took these needs into account. Appointments for older patients and those living in the more rural areas, people who have mobility problems and others who this would benefit were offered to co-incide with the timings of the local bus services to help patients access the practice more easily.
- The practice had recognised the specific needs of patients who were also carers and an identified member of staff who acted as a lead for supporting patients who were carers for others. In 2011 a carer's support group was set up and monthly meetings were held at the practice. All known patients who were carers were contacted and reminded of these meetings. Guest speakers were invited to give talks on a range of topics such as bereavement, power of attorney and health related matters including preventing and managing pressure sores. The meetings also provided opportunities for befriending and emotional support.
- The practice had reviewed its systems for reviewing the needs of patients with one or more long term condition and had implemented long term clinics for patients with cardiac conditions. These clinics allowed patients to attend one extended appointment for their reviews. The effectiveness of these clinics was audited and the practice reported that by combining patient reviews they had identified 8% of patients who would benefit from statin medicines to reduce their blood cholesterol levels.
- The practice had also reduced the number of appointments patients with long-term conditions needed to attend and patients responded very positively to this. Other practices within the locality commended this initiative and were considering implementing similar systems. The practice was looking to develop this system to cover other long-term conditions.

Lawns 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 practice manager specialist advisor.

Background to Lawns Medical Practice

Lawns Medical Practice is located in the rural town of Diss in Norfolk. The practice services a large geographical area including Roydon, Burston and Gissing. The practice provides services for approximately 6774 patients living in the area. It is situated in a health centre and shares its accommodation with Parish Fields Practice and a number of community services including health visitors and district nurses.

The practice is a partnership between three male GP's, and two salaried GP's are employed to cover one session each week. Three practice nurses and two health care assistants are employed. Lawns Medical Practice is not a teaching practice.

The practice is open between 8am and 7pm on weekdays. Same day and pre-booked advance appointments made be made in person, by telephone or online. Early morning appointments for blood tests and health care assistant appointments were available.

Lawns Medical Practice does not provide an out-of-hours service to patients. The out-of-hours services were provided by East Anglian Ambulance Trust. Details of how to access emergency and non-emergency treatment and advice was available within the practice and on its website.

Why we carried out this inspection

We inspected The Lawns Medical Practice 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.

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

How we carried out this inspection

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

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 November 2014. During our visit we spoke with a range of staff including GP partners, salaried GP's, practice nurses, health care assistants, reception and administrative staff and the practice manager. We spoke with patients who used the service. We talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed 33 comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff recruitment, training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). These alerts have safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety.

Complaints, accidents and other incidents such as significant events were reviewed regularly to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. We looked at records and saw that accidents, significant events and any other safety incidents were fully investigated and a root cause analysis was carried out to help determine where improvements could be made to avoid recurrence.

Staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

Records were kept of significant events that had occurred during the last twelve months and these were made available to us. We looked at records which showed that all ongoing significant events, concern and complaints of a serious nature were discussed with staff during the weekly practice meetings. These were also discussed and reflected upon at the GP partner meetings, which were held weekly. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example a number of significant events and incidents related to errors in medicine administration and labelling or handing of specimens. These incidents were investigated and found that nursing staff were regularly interrupted by reception and administrative staff during their consultations and appointments. Learning from these incidents was shared with staff and a system was put in place whereby reception staff used an enquiry tray to share messages with nursing staff so that they could be reviewed at the end of clinics and appointments. Nursing staff told us that this had proved to be effective in minimising such incidents. Investigations into safety incidents were reviewed periodically to ensure that staff learning was embedded in practice and patient safety was improved.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had designated GP leads for safeguarding vulnerable adults and children. These leads had oversight for safeguarding and acted as a resource for the practice. Staff we spoke with were aware of who the leads were and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's SystmOne electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example cared for children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Records showed that vulnerable adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings where local community nurses, health visitors and social workers were invited to attend.

Good

Are services safe?

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. Patients we spoke with were aware that they could have a chaperone during their consultation, if they wished to do so.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the SystmOne electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. The practice had a 'cold chain' policy and procedure to ensure that medicines such as vaccines were stored at the appropriate temperature so that that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date.

Information about the arrangements for obtaining repeat prescriptions was made available to patients. This information was displayed in the practice and available on their website. The practice followed national guidelines around medicines prescribing and repeat prescriptions. Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully.

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

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice provided on site dispensing services and patients could obtain their medicines when they attended appointments. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice employed an external cleaning company for the general cleaning of the premises. There were detailed cleaning schedules for cleaning staff. These schedules were completed and the facilities manager met with the cleaning company each month to audit the cleaning procedures and to identify any areas where improvements may be needed. All clinical staff including doctors, nurses and health care assistants were responsible for cleaning consulting and treatment rooms. Staff had cleaning schedules, which described their cleaning duties and these were checked to ensure that cleaning was carried out to a satisfactory standard. The practice had suitable infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing

with needle stick injuries. Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

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. We saw that audits were carried out annually to test the effectiveness of the infection control procedures within the practice and to identify any areas where improvements were needed. The results of recent audits were seen and where areas for improvements had been identified there were action plans in place to ensure that these improvements were made.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment such as an automatic external defibrillator were periodically checked and calibrated to ensure accurate results for patients. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. All equipment was regularly checked by the facilities manager and records were kept to show when these checks were carried out. Where appropriate equipment was serviced in line with the manufacturer's recommendations.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. Employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager told us that non-clinical staff did not have criminal records checks as it had been thought that these were not necessary as staff did not have direct unsupervised contact with patients. However they told us that upon reflection these checks would be carried out to help further minimise risks to patients as reception and administrative staff had access to patient's information and personal details. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were always enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures), or adverse weather conditions.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and a dedicated lead for facilities who had oversight for maintaining the practice health and safety practices. Health and safety information was displayed for staff to see.

Weekly, monthly and other periodic checks and audits were carried out to identify areas of risks and where improvements were needed. The results of audits were shared with staff during weekly and monthly meetings as were actions and learning points.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with

Good

Are services safe?

told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency equipment and medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). A dedicated emergency equipment trolley was located in one of the nurse's treatment rooms and a grab bag containing oxygen and emergency medicines was available to take to any part of the practice and the car park if needed. All staff asked knew the location of this equipment and records we saw confirmed these were checked weekly.

A detailed and comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had comprehensive arrangements and systems in place to prevent and deal with an outbreak of fire. A fire risk assessment had been undertaken that included actions required to maintain fire safety. This was reviewed annually to ensure that it covered all areas of risk. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log.

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 their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information, new guidance and changes to current guidelines was made available to and shared with staff by email notifications and during staff meetings. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance for antibiotic prescribing was comparable to similar practices.

The practice had dedicated GP leads 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. Healthcare assistant's skills and knowledge was continually developed to help support the practice.

Management, monitoring and improving outcomes for people

The practice achieved 84% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed well in comparison to the national and CCG averages.

The practice had reviewed its systems for reviewing the needs of patients with one or more long term condition and had implemented long term clinics for patients with cardiac conditions. These clinics allowed patients to attend one extended appointment for their reviews. The effectiveness of these clinics was audited and the practice reported that by combining patient reviews they had identified 8% of patients who would benefit from statin medicines to reduce their blood cholesterol levels.

The practice worked proactively to encourage patients between 40 and 75 years to attend for their health checks to help early diagnosis and prevention of certain health conditions such as **heart disease, stroke, diabetes, kidney disease and certain types of dementia.** The practice dedicated clinic appointments each week for these clinics and reported an increase in the uptake of these health checks, with on average 80 health checks carried out each quarter. An audit of the effectiveness of these clinics showed an increase in the detection of diseases including hypertension, high cholesterol and kidney disease, and appropriate treatments were commenced for these patients.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice participated in clinical audits and peer review, which led to improvements in clinical care. Clinical audits and peer review are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GPs told us clinical audits were often linked to medicines management information and safety alerts. We looked at records from two clinical audits, which had been carried out within the past year. For example we saw an audit regarding the prescribing of Domperidone (a dopamine antagonist medicine administered to reduce and treat nausea and vomiting). The audit was carried out following safety alerts about the risks of serious side effects in patients who have cardiac conditions. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. We saw the results of audits had been shared with both GPs and nurses within regular clinical meetings. Staff spoke of a culture of quality improvement and continuous learning within the practice. The practice was able to demonstrate how its audit work and changes to practice had led to improved outcomes for its patients, and particularly those patients with a long term condition.

Doctors in the practice undertook minor surgical procedures in line with their registration under the Health

Good

Are services effective?

(for example, treatment is effective)

and Social Care Act 2008 and NICE guidance. The staff were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Robust checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for three members of staff. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Nursing staff told us that they had personal development plans and in addition to their mandatory training they had three allocated study days each year to undertake training in areas of their specialist interest.

All new staff underwent a period of induction to the practice. There were tailored staff handbooks to support new staff according to their role and job description. Support was available to all new staff to help them settle into their new role and to familiarise themselves with relevant policies, procedures and practices.

Training and development needs were identified through annual appraisal of staff performance. Staff had personal development plans, which were kept under review. We saw that where staff had identified training interests that arrangements had been made to provide suitable courses and opportunities. Nursing staff told us that they had personal development plans and in addition to their mandatory training they had three allocated study days each year to undertake training in areas of their specialist interest. Records we saw showed that nurses and health care assistants received regular clinical supervision, support and advice from the GPs when needed.

The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had named GP's and nurses to act as leads for overseeing areas such as safeguarding, infection control, diabetes, unplanned admission avoidance, travel health and palliative care and treatment and staff training.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents e.g those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

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Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was

Good

Are services effective?

(for example, treatment is effective)

used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Records we saw showed us that that multidisciplinary meetings took place at the practice with a range of other health professionals in attendance to co-ordinate care and meet the needs of the patients. Palliative care meetings took place monthly and doctors and managers from the practice met with Macmillan nurses to ensure there was a joined up approach to care and treatment for the patient.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. Patients and staff told us that they were asked for their consent prior to any treatment being carried out. The practice nurse confirmed written consent was always obtained from parents prior to immunisations given to their child. We also spoke with parents of young children. They told us the clinicians confirmed their relationship with the child and whether they agreed that their child could be immunised before care was provided.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used 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.

Nurses and GPs we spoke with were aware of the Mental Capacity Act 2005. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

Health Promotion & Prevention

All newly registered patients were offered routine medical check-up appointments with a health care assistant. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months could book an appointment for a general health check-up.

There was a range of health promotion leaflets available in the waiting area with information to promote good physical and mental health and lifestyle choices. We saw information about mental health domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption, contraception. Sexual health and smoking cessation sessions were provided. There were also leaflets signposting patients to other local and national support and advice agencies. Information about health promotion was available on the practice website and patients were encouraged to access a local NHS supporting self-care booklet.

Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Through discussion with staff and from records viewed we saw that the practice performed well and had a high uptake for both childhood and adult immunisation and vaccinations.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with four patients and reviewed the most recent data available for the practice on patient satisfaction, including comments made by patients who completed comment cards. We also looked at information from the national patient survey and a survey of patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The Patient Participation Group conducted a survey and received responses from 162 patients from a range of age groups. The responses showed that over 90% of patients were happy with how all staff including doctors, receptionists and nurses responded to their needs. Patients indicated that they were listened to and treated with compassion and dignity. The practice scored above the regional average in the national patient survey for the percentage of patients felt that doctors and nurses listened to them and treated them with care.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 33 completed cards and the majority were positive about the service experienced. Patients said they felt the practice provided excellent care and treatment. Patients commented that staff were kind, efficient, helpful and caring. They said staff were respectful and treated them with dignity.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us that where patients wished to discuss any personal matters that they could be seen in private. Records showed that relevant staff had undertaken training on how to chaperone a patient, and were aware of the procedure. There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

The practice was easily accessible to patients with mobility issues. Corridors leading to consulting and treatment rooms were suitable for wheelchair access. There were disabled access toilets and baby changing facilities. There were hearing lop facilities for patients who were hearing impaired. The practice had dispensing services and patients could obtain their prescribed medicines on site. The practice had recognised that some patients may have difficulties obtaining repeat prescriptions and medicines and there were arrangements for monthly home delivery of medicines for patients who were housebound.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. Nurses demonstrated how they provided information, answered questions and obtained parental consent to baby immunisations. Staff were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

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 that the practice scored similar to other practices regionally in patient responses relating to how doctors and nurses listened to their concerns and involved them in making decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed

decision about the choice of treatment they wished to receive. They told us that information in relation to their health and the treatment that they received was explained to them in a way that they would understand. Patient feedback on the comment cards we received was also positive, the majority of the 33 patients who responded told us that they were happy with their involvement in their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Translation facilities were available on the practice's website.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified when they registered with the practice so that they could be identified and provided with information and support to access local services and benefits designed to assist carers. The practice had a delegated lead for supporting patients who were carers and there was a carer's support group. They showed us the list of 90 patients who were identified as carers. A carers meeting was held at the practice on the last Thursday of each month and the lead contacted patients by telephone to remind and invite carers to these meetings. The meetings provided practical sessions with guest speakers such as representatives form Age UK, social workers and district nurses. Topics discussed included issues such as power of attorney, pressure sore prevention and treatment and information about the range of services and support organisations was shared with participants. The meetings also offered opportunities for befriending and emotional support for patients who were carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

Staff told us families who had suffered bereavement were identified and the electronic records system was updated to alert nurses and doctors. They told us that recently bereaved families were called by their usual GP. This call was either followed by a patient consultation at the practice, or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations. Similarly calls were made to new mums following the birth of children to check how they were doing and to offer advice and support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice proactively supported certain patient groups to engage with the service, for example home visit reviews were offered to patients who had diabetes and were unable to attend the practice due to immobility or other conditions. Monthly diabetes outreach clinics were provided with the GP diabetic lead and a diabetic nurse specialist.

The practice had considered the specific needs for people with one or more long term condition and in order to improve outcomes for these patients had introduced a Long Term Clinic (LTC) for patients with cardiac related conditions. This allowed for patients to attend one appointment rather than several, thus reducing the impact upon patients and freeing up appointments. In the time that these clinics had been operation they had reduced the number of appointments for reviewing patients with long term dramatically. By combining appointments for patients with one or more long-term condition the practice provided 1320 appointments for 2292 patients, therefore freeing up appointment slots for other patients. The practice manager told us that patient's response to the changes in this appointment system had been overwhelmingly positive. The practice manager reported that other GP practices in the local area had sought advice on how they might implement similar systems within their own practices.

The practice worked collaboratively with other agencies such The local mental health team and Wellbeing services to provide appropriate treatment and support for people with mental health conditions. The practice jointly with NORCAS and TADS Recovery Partnership to support people affected by alcohol or substance addiction and weekly clinics were available at the practice.

We saw that the practice monitored individual clinical capacity and this ensured they were able to meet patient needs. Appointment times were flexible to meet the needs of patients from the different population groups. Early morning appointments with nurses and health care assistants for blood tests were available and GP appointments were available up to 7pm each evening to help serve working aged patients. Home visits with GP's and nurses were available where patients were unable to attend appointments at the practice. A monthly medicines delivery service was also available. The practice operated a duty doctor system and telephone consultations were available each day. Same day emergency appointments were available.

We found the practice had a high referral rate to specialist services. Nurses and GP's attributed to the early detection of conditions through the health assessment and screening checks provided by the practice nurses, which helped to ensure that patients received appropriate secondary and treatments in a timely way. Patients told us, they were informed of their test results promptly and that the GP discussed the results with them if further treatment was required.

The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. Patients who were carers were offered support through the carer's support group.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice operated an open list so that patients who were temporarily resident in the area could register as a temporary resident.

The practice had access to INTRAN translation services funded by the South Norfolk Clinical Commissioning Group. This service was predominantly a telephone based service; however translators could be requested to attend the practice if required. The service offered British Sign Language interpreters, lip speakers and interpreters in 150 languages.

Access to the service

The practice had developed an appointment system to meet the needs of patients. Early morning nurse and health care assistant appointments were available and the practice offered extended hours with evening appointments available up until 7pm each evening. Details of the services available, how to book, change or cancel appointments were posted throughout the practice and displayed on the website. There were also arrangements in

Good

Are services responsive to people's needs?

(for example, to feedback?)

place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Patients could access, change or cancel booked appointments via the practice website or the telephone booking system

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice was situated on the ground and first floors of the building. Services for patients were available on the ground floor. The practice was located within the Health Centre which it shared with Parish Fields Practice and various community teams. The Health Centre is located in the centre of Diss and is serviced by a pay and display council run car park, with the first hour free of charge

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The majority of the practice population were English speaking patients. There were arrangements for supporting patients whose first language was not English. The practice self-check in system and the website offered translation facilities in a number of languages.

Listening and learning from concerns & complaints

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The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for investigating and responding to complaints and concerns. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Staff were aware of these procedures and the designated person who handled complaints. Doctors, nurses and administrative told us that the practice had an open culture where they felt safe and able to raise concerns. They told us learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise

We looked at the summaries for nine complaints received in the last twelve months and found these were investigated thoroughly and sensitively. All complaints were recorded and investigated consistently in line with the practice's complaints procedures. On going and recent complaints or concerns were discussed at regular staff meetings to help ensure that staff were aware of any issues and learning from complaints and concerns. Patients we spoke with confirmed that when they had cause to complain or raise concerns that these were dealt with promptly and thoroughly.

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

Lawns Medical Practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision, values and future plans for the practice. The practice promoted an ethos by which patients received high quality care and where they were in charge of their healthcare. Patients we spoke with confirmed that they were encouraged and supported to do so. The practice charter, which described what patients could expect and what staff asked of patients, was available on the website.

The practice had a clear vision for the future and improvement of services they provided. The nurse –led long term conditions clinics had been set up to reduce the number of visits patients needed to make to the practice and to free up GP time to offer more consultations and appointments. However since its set up one of the GP's had left the practice. Despite an active recruitment campaign the practice had been unable to employ a GP. A decision was made to employ a nurse practitioner to support the service and improve the range of nurse-led services available. The nurse practitioner was due to commence their employment in January 2015.

The practice had clear leadership systems in place and a number of GP's and nurses took the lead in overseeing areas such as managing risks and improving quality and safety outcomes for patients. There were comprehensive risk assessments for clinical risks and other risks associated with the practice, including clinical practice, environment, equipment and staffing. We saw that all areas of risk were reviewed regularly.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, audits and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that there were clear leadership arrangements and everyone was aware of their roles and responsibilities within the team. A number of staff had lead roles, these included infection control, palliative care, safeguarding, and staff had oversight for procedures within the practice to help inform other staff and improve standards and safety.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. Roles and responsibilities were clearly defined and identified. We saw evidence that processes and procedures were working and in practice. The practice had robust systems for monitoring and reviewing the delivery of patient care and treatment. A range of audits and checks were regularly carried out to ensure that patients were treated in safe and appropriate premises and that they received safe and high quality care and treatments.

Monthly clinical governance meetings were held between the GPs and the practice manager. During these meetings decisions about clinical issues were discussed and any outstanding issues were reviewed and where appropriate resolved. We saw that the arrangements for patient appointments were regularly discussed to see if these could be improved. Other regular staff meetings were held where the day to day business of the practice such as skill mix, safety issues, new initiatives and clinical matters were discussed. Meetings were recorded and we were able to see that decisions had been made and communicated effectively. Any actions arising from these meetings were clearly documented, allocated to staff for completion, and followed up at subsequent meetings.

We saw the practice had achieved an overall achievement of level two with the 'information governance (IG) toolkit'. The IG toolkit is an online system which allows NHS organisations and partners to assess themselves against department of health IG policies and standards. It also allows members of the public to view participating organisations' IG toolkit evaluations. Level two is a satisfactory achievement for primary care services using this toolkit.

Leadership, openness and transparency

We found the practice manager and partners held regular practice meetings and this included reviewing the register of all accidents/incidents and significant events which had

Are services well-led?

Good

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

taken place, including lessons learned from them. There were also ongoing checks of the safe running of the practice such as legionella testing, infection control monitoring and fire safety.

The practice manager and clinicians were aware of the needs of the practice population and tailored the service to meet the needs of the local population groups. The clinical team had lead areas of responsibility as did each member of staff such as the practice nurses who led on infection prevention control and diabetes services. All worked closely and effectively to ensure patients received timely and appropriate care.

We found there was daily monitoring of the patient appointment system to ensure the system was accessible and responsive to patient needs. Patients who repeatedly failed to attend appointments were identified and written to advising them of the importance of attending appointments.

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG) The PPG is a forum made up of patient representatives and staff who discuss changes within the practice and how services could be improved for patients. There were posters and information on the practice website informing patients about the group and how to join.

The PPG conducted annual patient surveys. The results from the most recent survey, which was carried out in 2013 showed that the majority of patients were very happy with the care and treatments that they received and how they were treated by staff. The majority of less positive comments received related to the out of hours services. These comments were reviewed by the practice team and it was decided that until current NHS England and BMA discussions regarding the proposed 8 am until 8 pm, seven days a week opening for general practice was finalised that the practice should await government instruction.

Patients we spoke with told us that they were aware of the patient group. Those who were unable to be part of this group told us that they were always listened to by staff at the practice. Members of the patient group said that they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and nation GP survey

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality, safe and effective care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.