Mansion House

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 25 March 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 Nurse.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients identified as having severe mental health needs were offered an annual review with the practice nurse and the community psychiatric nurse at the practice, so both their physical and mental health needs could be reviewed during one appointment.
- 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.

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

The provider should:

Summary of findings

- Ensure there is a system in place to discuss and review actions for significant events on a regular basis.
- Strengthen the infection prevention and control processes.
- Carry out risk assessments to manage and monitor the risks to patients, staff and visitors.
- Introduce a system to ensure the checks on patients' abnormal results are followed through.
- Ensure all staff understand the Mental Capacity Act 2005 and implications for their practice.
- Ensure there is a system in place to review complaints for any trends or themes.
- Ensure policies and procedures are regularly reviewed and updated.

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, although not always in a timely manner. The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However, the practice had not systematically identified risks and recorded these in a risk log.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's 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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all 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 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. 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.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to access urgent appointments available the same day and to make an appointment but not necessarily with their preferred GP. The practice had good facilities and was well equipped to treat patients

Summary of findings

and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

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 leadership structure 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. The practice was participating in the Frail Elderly Project, which identified the most vulnerable patients in the older population who required additional support. It was responsive to the needs of older people and offered home visits and telephone access to the practice nurses for guidance and support. The practice identified if patients were also carers, and information about support groups was available in the waiting room.

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 were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of accident and emergency attendances.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 eight week check, at which they saw the GP, practice nurse and health visitor.

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

Summary of findings

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 one evening and Saturday morning on alternate weeks. 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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 or of no fixed abode. 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 had a good working relationship with the community psychiatric nurse. Patients experiencing poor mental health received an annual health review with the practice nurse and the community psychiatric nurse, to ensure appropriate treatment and support was in place. The practice was part of a pilot for the dementia care project, aimed at getting a more timely diagnosis of dementia.

Summary of findings

What people who use the service say

We spoke with seven 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 10 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 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.

We looked at the national GP Patient Survey published in January 2015. The survey found that 82% of patients described their overall experience of the practice as good. The results showed that 76% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is a system in place to discuss and review actions for significant events on a regular basis.
- Strengthen the infection prevention and control processes.
- Carry out risk assessments to manage and monitor the risks to patients, staff and visitors.
- Introduce a system to ensure the checks on patients' abnormal results are followed through.
- Ensure all staff understand the Mental Capacity Act 2005 and implications for their practice.
- Ensure there is a system in place to review complaints for any trends or themes.
- Ensure policies and procedures are regularly reviewed and updated.

Mansion House

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 Practice Manager specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Mansion House

Mansion House is located in the town of Stone, Staffordshire. The practice provides services to people who live in Stone and surrounding villages. The practice covers an area which is approximately a circle with a five mile radius around Stone.

The practice has nine GP Partners and three salaried GPs (eight male and four female), three GP registrars, four practice nurses, a healthcare assistant, a phlebotomist, a practice and assistant practice manager and reception and administrative staff. There are 13336 patients registered with the practice. The practice is open from 8am to 6.30pm Monday to Friday, with consultations available between 8.30am and 11.30am and 3.10pm and 5.50pm. The practice treats patients of all ages and provides a range of medical services. Mansion House has a higher percentage of its practice population in the 65 and over age group than the Clinical Commissioning Group (CCG) average.

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 provides a number of clinics for example long term condition management including heart disease, asthma and other chronic lung conditions, prediabetes and diabetes and high blood pressure. It offers antenatal care, child immunisations, minor surgery and travel health.

Mansion House has a contract to provide General Medical Services.

Manson House 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 will be provided by North Staffordshire Doctors Urgent Care from April 2015.

Why we carried out this inspection

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

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included Stafford and Surrounds Clinical Commissioning Group, Healthwatch and NHS England Area Team.

We carried out an announced visit on 25 March 2015. During our inspection we spoke with six GPs, a locum GP, a registrar, two practice nurses, the health care assistant, the practice and assistant practice manager, and reception and administration staff. We spoke with seven patients (four of which were also members of the patient participation group) who used the service about their experiences of the care they received. We reviewed 10 patient comment cards sharing their views and experiences of the practice. We also spoke with external professionals who worked in liaison with the practice. These included the community psychiatric nurse and representatives 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 saw there were safety records and incident reports for the last eight years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last seven years and we were able to review these. Significant events were not a standing item on the practice meeting agenda, but were discussed under any other business. A dedicated meeting to discuss and review actions from past significant events was not held. The management team recognised the weakness in this system as significant events were not always discussed and reviewed in a timely manner. However, there was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators 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 practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and outcome. One incident related to overhearing confidential information at reception. As a consequence the reception area had been reorganised and training provided for staff on confidentiality. We saw that no further complaints regarding this issue had been received. Significant event forms were saved on the shared drive and therefore accessible to staff.

National patient safety alerts were disseminated by the practice data administrator to practice staff. Nursing staff told us they were responsible for acting on any alerts relevant to their area of care.

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 the majority of staff had received relevant role specific training on safeguarding. We asked members of medical and nursing 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.

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. They were able to show us examples of when patients at risk had been discussed to ensure the appropriate action had been taken. They also told us they if a child at risk did not attend an appointment or attended accident and emergency they would review the records to identify if any action needed to be taken. The care of children on the register was discussed during practice meetings. Staff were aware of which GP was the safeguarding lead, and told us they could also discuss any concerns with the practice manager.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

There was a chaperone policy which was visible in the consulting rooms and advertised in the waiting room. (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. Members of the nursing team 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. Patients spoken to told us they were offered a chaperone.

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. 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 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, both before and after the clinic. The GP safeguarding lead told us that any discussions were recorded in the patients' notes.

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.

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. The practice had established a service for patients to collect their prepared prescriptions at a number of locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by the Clinical Commissioning Group (CCG) prescribing advisor. A member of the team visited every two weeks and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. There was an agreement in place with the practice so that the prescribing advisor could initiate changes to patient medicines in response to updates. The member of staff responsible for repeat prescriptions notified patients of any changes. We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing.

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), although two of the GP partners did. We were told that the medicines were stored securely at all times, and a register

maintained. We were unable to verify this as neither GP was available on the day of inspection. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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. They told us that staff had received in house training about infection control specific to their role. The training was updated annually, and plans were in place for all clinical staff to attend external training. Infection control audits had not been carried out.

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. Spillage kits were available to manage any spillage of bodily fluids.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that clinical staff had received appropriate immunisations and support to manage the risks of health care associated infections. However, the practice had not risk assessed whether staff within other teams, for example cleaning staff, required protection. 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.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

The practice had a policy 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 the practice was carrying out regular checks in line with this policy 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 calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

The GP partners had recognised the need to increase the skill mix and number of clinical staff to meet the needs of the practice population. Salaried GPs had been recruited to provide additional cover for holidays and sickness, as well as increasing the number of appointments available. A regular locum GP was used to cover any long term sickness amongst the GP partners. The practice were actively recruiting an additional practice nurse, and hoped to employ an additional health care assistant in the future.

Staff sickness within the administration team had highlighted the need for staff to be multi-skilled. Staff were undertaking additional training on the different areas of work to enable sufficient cover for holidays and sickness.

Good

Are services safe?

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

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing and dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice had not identified risks and recorded these in a risk log. The practice manager told us they carried out opportunistic risk assessments, for example when the boiler required repair. However, there was no evidence to support this.

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. 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. Risks identified included power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Staff had not attended fire training or a fire drill since 2012. However, training had been arranged to take place during the protected learning time.

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 to them and discussed within the nursing team. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

One of the GP partners told us that the local Clinical Commissioning Group (CCG) bench marked them against other practices in the locality. The information was shared with the practices on a monthly basis a newsletter 'Plan on a Page'. We looked at the newsletter for February 2105, which showed how the practice compared to other practices for dementia diagnosis rate, out patient referrals and accident and emergency attendance.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The information staff collected was then collated by the assistant practice manager to support the practice to carry out clinical audits.

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 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 used the electronic system to alert clinical staff to collect QOF data when patients attended for a consultation or a home visit was carried out. The practice achieved 97.1% QOF which was above the national average. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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. The practice nurses provided additional support for these patients via telephone advice. The practice told us there was an overlap of these patients with those identified as part of the Frail Elderly project.

The practice showed us three clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. This related to improved outcomes for patients undergoing minor surgery, as there had been a reduction in the number of wounds that broke down. The second audit cycle was in progress for the other two audits.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice was supported by the prescribing advisor from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. There was an agreement in place for the prescribing advisor to amend patients' medicines as required.

We saw that the practice sent letters to patients to ask them to come in to discuss their results if abnormal. However, a system was not in place to ensure that the patient attended for their results. We discussed this at the time of the inspection with the practice manager and registered manager. They told us they would look to introduce a system to check that all patients with abnormal results were reviewed by the GP.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and

Good

Are services effective?

(for example, treatment is effective)

saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with four having additional diplomas in sexual and reproductive medicine, and one with a diploma in geriatric medicine. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There was protected learning time each month, with each section of staff attending training relevant to their role The nursing staff told us they also completed on line training through the Royal College of Nursing. 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. Each GP partner had a lead role for long terms conditions and supported the nursing team with the management of these patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every six to eight weeks to discuss the needs of complex patients, for example those with end of life care needs ore receiving care from the community nurses. The palliative care meetings were attended by district nurses, the palliative care specialist practitioner, hospice staff, Stone Rehabilitation services and the practice GP. All patients on the palliative care register were reviewed at these meetings, and any addition care requirements discussed. 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.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. Administration staff told us the GP would hand write the letter and attach the summary record to the letter. The practice has also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We saw that the practice had policies and guidance 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.

Staff had not received training on the Mental Capacity Act 2005. 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. Nursing 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.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We reviewed practice records which showed that 80% of patients on the register with dementia had been reviewed in the last 12 months.

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. Nursing staff told us that they obtained parental consent before administering child hood immunisations.

Health promotion and prevention

The practice attended Clinical Commissioning Group (CCG) locality meetings to review and discuss best practice and develop new initiatives. They told us recently they had discussed the flu vaccination campaigns and management of chronic obstructive pulmonary disease (chronic lung disease). This information was used to help focus health promotion activity.

All new patients were required to complete a health questionnaire as part of the registration process. This included information about medical conditions, family history, smoking and alcohol intake. These questionnaires were reviewed by a GP and the patient invited for a health check if required.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, in house smoking cessation programmes and referrals to the Weight Watchers for weight management. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The nursing staff told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They had a range of leaflets available to give to patients, and leaflets were also available in the waiting room. The leaflets in the waiting room would be more accessible to patients if separated out and tidied up.

The practice offered sexual health and family planning advice and support. Chlamydia screening was available for patients aged 18 to 25 years, and the testing kits were available for patients to take away. The practice also offered a free condom service.

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 in line with the average for the CCG, and there was a clear policy for following up non-attenders.

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.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and these patients were offered an annual physical health check. The practice had also offered smoking cessation advice through nurse led clinics to 94% of identified patients who smoked

Good

Are services effective?

(for example, treatment is effective)

over the age of 16. There was evidence this were having some success as the number of patients who had stopped smoking in the last 12 months was 84. The practice's performance for cervical smear uptake was 81.5%, which was in line with the national average. There was a policy to send reminders for patients who did not attend for cervical smears.

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 118 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 285 patients undertaken by an external company on behalf of the practice, report dated February 2014. The practice also received comments from the patient participation group (PPG). 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 all these sources showed patients were satisfied with how they were treated and that this was generally with compassion, dignity and respect. For example, data from the national patient survey showed that 82% of patients rated their overall experience of the practice as good. The survey showed that 92% of patients felt that the doctor was good at listening to them, and 91% said the GP gave them enough time. Both of these results were above the local Clinical Commissioning Group (CCG) average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received ten completed cards and the majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 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. Disposable 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Although the practice switchboard was located at the reception desk, staff were shielded by glass partitions which helped keep patient information private. There was a system in place to allow 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.

We saw that any concerns regarding staff behaviour were addressed by the practice manager. The practice manager had investigated the concerns and learning identified and shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence that learning had taken place as the incident had been incorporated into a staff training event.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists had received training on skills required to help them diffuse potentially difficult situations.

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. One patient told us the GP had also printed off information for them about their condition, and explained it to them in simple terms. Patients' comments on the comment cards we received were also positive and supported these views.

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 carried out during January-March 2014 and July-September 2014 showed 78% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 82% of practice respondents said the nurse involved them in care decisions and 92% felt the nurse was good at explaining treatment and results. The results from the survey carried out by the external company were similar, and demonstrated an increase in patient satisfaction in these areas from the previous survey in January 2013.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us

they had access to interpreters, although patients were often accompanied by a family member who spoke English to support them. Clinical staff were aware of the challenges around families translating for patients.

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, those with mental health difficulties or dementia, complex health needs or end of life care. The practice was part of local initiative to identify frail elderly patients, and individual care plans had been developed and agreed for these patients. A range of multi-disciplinary meetings between practice staff and community staff, including palliative care, district and mental health nurses were held regularly to review care plans for patients. The GPs told us that they updated patients' records during the meeting, to ensure that all relevant information was recorded. 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.

Patient/carer support to cope emotionally with care and treatment

The national 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 94% 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.

Leaflets in the patient waiting rooms and on the website told people how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was also a carer. Patients and carers were also signposted to support organisations through the Frail Elderly project and the dementia care project.

Staff told us that if families had suffered a bereavement they were offered support. All staff were made aware so they were sensitive to the situation if a family member contacted the practice. Families could be referred for bereavement counselling, either through the NHS or voluntary sector.

Nursing staff told us they were aware that patients with long term conditions also needed emotional support, especially when newly diagnosed. They told us they would spend time discussing patients concerns during consultations and advising on life style changes if required. They also told us support was available from secondary care, for example cardiac rehabilitation services.

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 extended hours each week for patients with work commitments or who were unable attend during routine opening hours. The practice offered a range of enhanced service, for example invasive minor surgery, coil and implant fitting and anticoagulation monitoring for patients taking warfarin (blood thinning medicine). The practice also provided a range of clinics for the management of long term conditions, such as asthma, chronic obstructive airways disease (COPD), heart disease and diabetes.

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. As part of an enhanced service the practice had identified patients most at risk of unplanned admissions. The practice nurses visited each of the patients identified and developed individual care plans with them. Allocated time was available so that patients could contact the nurses for advice if they wished.

The practice actively engaged in Clinical Commissioning Group (CCG) projects. The practice was a pilot practice for the 'Frail Elderly Project', a project aimed at identifying the most vulnerable patients in the older population who require additional support. Those patients identified with increasing needs were seen by a GP and detailed care plan developed in agreement with the patient. A copy of the care plan was left with the patient to inform other health professionals of the issues and wishes for care that the patient had. The care plan was also added to the electronic patient records held at the practice. The practice was also part of the dementia care project, which was aimed at providing a more timely diagnosis of dementia.

The practice engaged with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. The practice attended the local CCG meetings and told us that these meetings provided effective two way communication. The assistant practice manager represented that practice at the innovation meetings, to review and share good practice and develop new initiatives. Issues such as flu vaccination campaigns, transforming end of life care and dementia had recently been discussed at these meetings. The practice manager also attended the practice managers meetings.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). 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. Following comments from the PPG, the practice now informed patients via the television screen in the waiting room if a GP was running late.

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 and spoke highly of the GPs and Practice Nurses. They told us the GPs would visit on request and telephone advice was also provided as required.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, the travelling fairground community, people passing through the town on narrow boats, patients with a learning disability and students. Staff told us that these patients were supported to register as either permanent or temporary patients. Reception staff told us how they had recently supported a person with no fixed abode to register at the practice. 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.

Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member or friend who would translate for them. Staff told us they had access to interpreters if required. We did not see any leaflets in different languages for patients, although information could be translated via the website. There were four permanent female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building, with services for patients on the ground floor. There was a hearing loop system available for patients with a hearing impairment. 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. 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 (located in the female toilets only).

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 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. There were also 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. The practice offered urgent same day appointments or urgent telephone consultations and routine pre-bookable appointments. Consultation times were between 8.30am and 11.30am and 3.10pm and 5.50pm. Information about the working patterns of each doctor was in the practice booklet and on the website.

Extended opening hours were also provided one day a week. Routine appointments were available between 6.30pm and 8.15pm on alternate Mondays and 8.30am until 12 noon on alternate Saturdays. These were particularly useful to patients with work commitments, and could be booked up to four weeks in advance.

As a result of comments made in the patient survey and feedback from the PPG, the practice had reviewed the capacity and booking patterns of appointments. Capacity had been increased by employing an additional salaried GP and additional GP consultations between 12 noon and 3pm one day a week. The appointment system had been altered so that only urgent appointments could be booked on the day, with pre bookable available up to two weeks in advance. On Mondays and Fridays the ratio of urgent on the day appointments to pre bookable was increased to meet patient demand. Two GPs provided duty cover each afternoon, which provided greater flexibility to see additional urgent requests for appointments or home visits.

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. The data from the national GP survey supported this. 81% of respondents stated that they were able to get an appointment last time they tried and 89% said the last appointment they got was convenient. However only 38% were able to make an appointment with their preferred GP, which was below the local CCG average of 62%. However, patients told us that following the changes to the appointment system, they were also seen on the day if they requested this, and usually they book a routine appointment with any GP (not necessarily their preferred GP) within four days. They also commented that although some GPs did not always run to time, they were now kept informed of delays via the television screen.

Longer appointments were also available for patients who needed them and those with long-term conditions. However, the nurses commented that it would be beneficial to have longer routine appointments for patients who have a learning disability, to allow for the extra time to explain everything and ensure the patient fully understood.

Home visits were made to seven local care homes on request. The practice also supported patients with learning disabilities accommodated in supporting living. These patients usually attended the practice for appointments.

The practice offered a monthly mental health clinic for patients identified with severe mental health needs, in conjunction with the community mental health nurse. Patients were invited to attend these clinics for their annual review and their physical and mental health needs were reviewed during the one appointment. We spoke with the community psychiatric nurse who told us these clinics worked well, and they had a good working relationship with the practice. They told us the clinics helped to identify if a patient needed to be referred back to secondary care

Good

Are services responsive to people's needs?

(for example, to feedback?)

services, or required a change in medication that could be facilitated by the GP during the review. They told us that if the patient was involved with secondary care services, their care plan was shared with the practice.

The practice was able to offer routine appointments outside of school hours for children. Children were always offered a same day appointment if requested. Systems were in place to monitor mothers to be, from confirmation of pregnancy through to the eight week post natal check. Family planning services were available and the practice offered the free condom service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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 complaints leaflet, 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.

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. 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 did not have a system to review complaints annually to detect themes or trends, or hold a dedicated meeting to discuss and review actions from past complaints. The management team recognised this as a weakness in the complaints system.

We saw that the practice had made changes as the result of complaints. For example the appointment system had been changed and the waiting for routine appointments had reduced during the previous three months. The practice had also introduced a system to inform patients if the GPs were running late. We also saw that the practice used complaints as a learning opportunity, for example how to manage requests for urgent appointments.

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 statement of purpose and minimum standards agreement, both of which were on the practice website. It was clear when speaking with the GPs and the practice staff that they shared these aims and were committed to providing excellent 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.

The GP partners had invited the NHS England Area Team to review the practice through the Supporting Change in General Practice project and identify any potential areas for improvement. The practice were currently reviewing the findings and developing an action plan to address the areas for improvement identified.

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. However, the policies had not been reviewed in line with the dates and consequently contained information that was out of 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 each of the GP partners had lead roles, including safeguarding, medicines management and long term conditions. 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 it was performing above the national average. We saw that QOF data was regularly discussed at monthly management meetings.

The GPs told us about a local peer review system they took part in with a neighbouring GP practices. We looked at the report from the last peer review, which showed that the practices had reviewed referrals to two specialities within secondary care. The process of the peer review was to identify factors which could be addressed resulting in altered referral patterns.

The practice had some arrangements for identifying, recording and managing risks, although these need to be strengthened. The practice did not have a risk log to address a wide range of potential issues. Risk assessments had not been carried out where risks were identified or action plans produced and implemented.

Leadership, openness and transparency

We saw that a range of staff meetings were held monthly. 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 agenda for the practice meetings. The meeting was used to discuss a range of topics, including ongoing monitoring of performance, delivery of enhanced services and feedback from the local Clinical Commissioning Group.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as the induction policy and equality and diversity which were in place to support staff. The policies were all stored electronically and 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 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 patient experience survey highlighted issues around appointments and waiting times. The results of the survey and action plan were available on the practice website.

Are services well-led?

Good

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

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 Patient Participation Group (PPG). The practice also utilised the patient participation 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 practice was able to evidence through discussion with the GPs, staff and practice 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. However a dedicated meeting to discuss and review actions from past significant events was not held. The management team recognised the weakness in this system as significant events were not always discussed and reviewed in a timely manner. The practice also shared 'soft intelligence' regarding medicines to the prescribing advisor from the local Clinical Commissioning Group and other 'soft intelligence' was reported direct to the Midlands and Lancashire Clinical Support Unit.

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.

The practice was actively engaged with the local Clinical Commissioning Group and therefore involved in shaping local services. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. For example one GP was a representative on the governing body of the Clinical Commissioning Group (CCG) as a clinical lead, another employed by the CCG one session a week on the Primary Care Training and Workforce Development Group. This GP was also the Local Medical Committee (LMC) representative on the membership board. LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. The practice manager also represented the practice on the membership board.