Moss Green Surgery

Quality Report

Moss Green 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 carried out an announced comprehensive inspection at Moss Green Surgery on 15 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. The practice was found to be good for the services it provided 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 across all the areas we inspected 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.
- Risks to patients were assessed and well managed.
- 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 with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should

Summary of findings

- Maintain consistent records of meetings to clearly demonstrate the discussions and actions taken to address safety incidents (significant events, complaints, NICE guidelines etc.) over the long term.

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. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Patients who used the service told us that they felt safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. A clear and structured approach to meetings was needed to clearly show that lessons learned from significant events/incidents, near misses, complaints and safeguarding concerns were disseminated to staff. Risk management was comprehensive and recognised as the responsibility of all staff. There were enough staff to keep people safe.

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 told us that they referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. However formal systems were not in place to show that NICE guidance and its implications for the practice was regularly discussed at staff meetings. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses. 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. Feedback from patients about their care was positive. Data showed that patients rated the practice at or above average 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 saw that staff on the whole treated patients with kindness and respect, and were aware of the importance of maintaining confidentiality.

Summary of findings

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 NHS England and their local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

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. We found however, that not all policies and procedures were dated to reflect when they were reviewed. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and 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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability. To support the diverse needs of vulnerable patients the practice worked closely with various groups of locality based services and professionals. These included health visitors, social services, the learning disability team and the police. The practice had close links with these groups and was able to make appropriate referrals and signpost patients to appropriate professionals and support services that could help them. The advance nurse practitioners had received training and had the necessary skills to support the needs of patients that misused substances and patients who were homeless.

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). All patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with 19 patients during our inspection. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were respected, well cared for and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by staff.

We reviewed the 27 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and approachable.

The July – September 2014 national GP patient survey showed that practice performed well in the following areas.

- 91% of respondents found it easy to get through to the surgery by phone as compared with the local CCG average of 78%
- 88% of respondents describe their overall experience of the practice as good or very good compared with the national average of 86.7%

areas where the practice performed less well than the CCG average were identified in the national patient survey and included:

- 39% of respondents with a preferred GP usually get to see or speak to that GP compared to the local CCG average of 62%
- 71% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care compared with the local (CCG) average of 80%

Areas for improvement

Action the service SHOULD take to improve

- Maintain consistent records of meetings to clearly demonstrate the discussions and actions taken to address safety incidents (significant events, complaints, NICE guidelines etc.) over the long term.

Moss Green Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisors a GP and a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Moss Green Surgery

Moss Green Surgery is one of two practices in Stoke on Trent owned by the four GP partners. The other practice is Moorcroft Medical Practice. Moss Green Surgery forms part of the Bentilee Neighbourhood Centre in Stoke on Trent. The practice is located centrally within the Bentilee housing estate and is a purpose built premises rented under a sub-contract with Stoke on Trent NHS. The practice boundary is clearly defined for patients. There is a high level of deprivation and unemployment within this area of Stoke on Trent. The practice is located within the same premises as other local authority and health services.

There are four GP Partners, five salaried GPs and one sessional GP at the practice (six male and four female). The clinical team also include five advanced nurse practitioners, three practice nurses, (4.54 WTE) and one healthcare assistant (0.54 WTE). A managing partner, three practice manager's, reception, administrative and secretarial staff provide admin support for both practices.

The practice currently provides a service for 6,900 patients registered with the practice. Services provided at Moss green Surgery include the following clinics; contraception and sexual health, asthma, diabetes and wellbeing screening clinics.The practice population is mainly young children/young adults and older people aged 80 years plus. The practice also has a high percentage of single parent families.

The practice is approved for GP training of Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine). The practice is also an accredited teaching and training practice for medical students and offers administrative apprenticeships to local college students'.

The practice has an General Medical Services (GMS) Plus contract with NHS England for delivering primary care services to their local community.

The practice does not provide an out of hour's service to their own patients. They have alternative arrangements with Staffordshire Doctors Urgent Care Ltd. (SDUC) for their patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, Stoke on Trent CCG and the local Healthwatch to tell us what they knew about Moss Green Surgery and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 15 December 2014. During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, healthcare assistants and reception and administration staff. We spoke with 19 patients and two members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, records showed that an incident between patients which resulted in injury while waiting in the waiting area was appropriately handled. The outcome showed that the procedures to manage aggressive situations were followed by staff and had been effective.

We reviewed safety records, audit and incident reports and found that these were not always recorded in minutes of meetings to confirm and evidence the discussions that had taken place over time and demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

Staff, including receptionists, administrators and nursing staff, told us that they could raise concerns if they felt patients were at risk and felt encouraged to do so. There were summary records of significant events that had occurred during the last three years and we were able to review these. We were told that meetings took place to discuss complaints, safety and significant events. However the practice staff could not provide evidence to demonstrate that these topics were a standing or regular item discussed at meetings. However Information in the individual incident records, for example complaint summaries and significant event reports stated that the findings were shared with relevant staff.

Staff completed forms to report incidents to the practice manager. We were shown the system to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. For example, we saw evidence of the investigation and learning for both patient and staff following the delayed diagnosis of a long term condition. The practice reviewed its systems to ensure follow up tasks related to patients' treatment were identified. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us that alerts were discussed at practice meetings or at their protected learning days dependent on the topic. This ensured that all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records we looked at showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent 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 appointed a dedicated GP as the lead in safeguarding children and a second GP as the lead for safeguarding vulnerable adults. They had both been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead GPs were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, if a patient was a carer or patients with learning disabilities.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. These staff were aware of their role and where they should stand during the procedure.

We found that GPs used the required codes on their electronic case management system to ensure risks to

children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors, social services and police where appropriate.

Patients' individual records were written and managed to ensure confidentiality and safety. Patient records were kept on an electronic system which collated all communications about patients including scanned communications from hospitals.

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. The practice staff followed the policy. For example a record of the vaccine fridge temperatures were recorded daily to ensure that the vaccines were stored in line with the manufacturers guidelines and therefore safe to use.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions and evidence that nurses had received appropriate training to administer vaccines. The advanced nurse practitioners were qualified as independent prescribers. They received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of audits that identified best practice actions to be taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for various illnesses that patients presented with such as ear infections. Action taken included instructing clinicians to clearly record their reasons for prescribing specific antibiotics in patients' records.

There was a process for repeat prescribing which was in line with national procedures and was followed in practice. For example, all prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out regular audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

We saw records that confirmed the practice was carrying out regular checks in line with their policies to reduce the risk of infection to staff and patients. Staff were checked for their immunisation status as part of the practices' pre-employment health assessment process. This was a preventative measure to protect staff from the risk of

infection while undertaking their role. The infection control policy also included information on how to deal bodily fluid spills. There were procedures in place for the safe disposal of sharps and clinical waste.

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 premises management team 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, spirometers and blood pressure measuring devices, medicine refrigerators and computer equipment.

Staffing and recruitment

We saw that the practice had a robust recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, a full work history, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. There were systems in place to check that clinical staff registrations with their professional bodies were in date.

The practice employed sufficient and suitable staff to meet the needs of their patients. We saw that the practice was proactive in reviewing and amending its staffing skills and levels. Staff told us there was usually enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw that there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty.

There was also an arrangement in place for members of staff, including GPs, nursing and administrative staff to cover each other's annual leave and sickness where possible. Staff were trained to undertake and support each other's roles when needed. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Patients we spoke with told us that they had not experienced any problems with getting an appointment with a GP or practice nurse.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; emergency lighting tests and fire alarm testing.

We saw that where risks were identified action plans had been put in place to address these issues. An external company was responsible for security, safety and maintenance of the premises. The manager showed us the risk management reports that also covered the practice. Action logs were maintained and discussed with the practice where appropriate.

The practice had emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example the advanced nurse practitioners carried out home visits to patients who felt their health had deteriorated but they were to unwell to visit the practice. These patients were first contacted by telephone and an assessment made to determine whether a visit was necessary. The nurse could contact the duty GP by telephone at any time to discuss the patients care. One of the advanced nurse practitioners told us that on occasions their visit had resulted in the patient being admitted to hospital.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all clinical 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 weekly to ensure it was fit for purpose.

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, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and the loss of domestic services.

The premises management team had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that a practice fire drill had been carried out last year.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GPs and nurses told us that they completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. We found however that although staff could tell us about the process they followed to look at and discuss this guidance that these discussions were not mentioned in the minutes of meetings we looked at.

The GPs told us they led in specialist clinical areas such as obstetrics, substance misuse, mental health and ear nose and throat health (ENT). The advanced nurse practitioners and practice nurses supported this work. The GP partners were responsible for the majority of lead roles. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff told us that they were supported to continually review and discuss best practice guidelines. An example included a review of the guidelines for prescribing a specific antibiotic (Co-amoxiclav). We saw that an audit looked at the implications for the practice's performance and their patients. These were discussed and required actions agreed. The report we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their records. We were shown the process the practice used to review patients recently discharged from hospital and saw that these patients were regularly reviewed. Unplanned admissions were discussed at practice meetings and a visit carried out where appropriate. The practice had completed care plans for all their patients identified to be at risk. These included patients with a learning disability, patients with dementia and those experiencing mental health problems.

National data showed that the practice was performing well for referral rates to secondary and other community care services for some conditions. The rates for patients who attended accident and emergency were below the national average when compared to other practices within the Clinical Commissioning Group (CCG).

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. GP trainees and medical students were included in this process. The information staff collected was then collated by staff to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us seven clinical audits that had been undertaken over a number of years. Audits had repeated clinical cycles or planned dates to reassess ongoing improvement. The outcomes of audits were used as a learning tool. For example we saw that two cycles of a diabetic audit had been carried out between 2013 and 2014. The first audit cycle identified patients of South Asian, Chinese, Caribbean and Black African descent aged 25-39 inclusive for whom a risk assessment had been completed and were considered to be at high risk of developing diabetes. Nineteen patients were identified. Patients were contacted and a series of lifestyle advice, health checks and investigations commenced. The second cycle involved assessing if the patients identified had improved their risk score after lifestyle advice. Although the audit showed poor compliance related to patients having more than one illness and the level of deprivation in the area overall the practice saw a 50% improvement as a result of their interventions.

The GPs told us that clinical audits were also linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

Good

Are services effective?

(for example, treatment is effective)

The practice had noted that they were performing below average for patients with chronic kidney disease. We saw that the practice had used the local benchmarking run by the Clinical Commissioning Group (CCG) quality improvement framework (QIF) to address the standards where the practice was not performing well and to ensure improvements were made. This process involved evaluating performance data from the practice and comparing it to similar GP practices in the area. This benchmarking data showed the practice had some outcomes that were above or just below average when compared to other services in the area.

The team made use of clinical supervision, appraisals and staff meetings to assess the performance of clinical staff. GPs held weekly practice meetings which were attended by the practice managers, advanced nurse practitioners and the practice pharmacist. The different groups of staff held individual team meetings every month and all staff groups participated in protected learning events each week. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where improvements could be made. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice information technology (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. Where the GPs continued to prescribe the medicine they outlined the reason why this decision had been made. The practice 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

The practice maintained a palliative care register and had monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice involved patients in making decisions about their care and treatment for as long as possible.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that clinical and non-clinical staff were up to date with attending mandatory courses such as basic life support. We noted a good skill mix among the GPs, advanced practitioners and practice nurses. GPs had specialist interests in substance misuse and mental health and had completed courses in diabetic care, management of substance misuse and family planning. All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice was a training practice, GP registrars who were training to be qualified as GPs had access to a senior GP throughout the day for support. The practice was also an approved training centre for medical students.

Advanced nurse practitioners and practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of childhood immunisations and cervical screening. Those with extended roles such as in coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. All the advanced nurse practitioners were prescribers and had a physical assessment qualification. The physical assessment qualification provided nurses with the skills and knowledge to obtain a comprehensive patient history, to perform a complete physical assessment of all body systems and to distinguish normal findings from pathological ones. There was a structured programme of support for advanced nurse practitioners from their peers who were more experienced in their roles and ongoing GP support.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results,

Good

Are services effective?

(for example, treatment is effective)

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 worked well with other local authority and health services working at the same premises. This included the learning disabilities team and health visitors. The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, community matrons and palliative care nurses. Decisions about care planning were documented in a shared care record. We saw that the practice worked with midwives to assist in the provision of antenatal care to pregnant women and health visitors to support the care of babies and young children. The practice worked with the local primary care mental health team to provide appointments at the practice for patients experiencing poor mental health.

The GPs provided mentorship support for community nurses undertaking independent nurse prescribing qualifications.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw that the practice had a system in place for recording and reporting incidents and significant events supported learning and improved information sharing between the practice and other providers.

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.

The practice had 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).

Consent to care and treatment

There were systems in place to seek record and review consent decisions. For example, where verbal consent was required for intimate procedures, a patient's verbal consent was documented in their electronic records. For other procedures, including minor surgery and therapeutic injections, written consent was obtained. We saw a form that patients signed to acknowledge that the procedure, the benefits and risks had been explained to them before they gave their consent. We saw that patients had signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

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 to. The plans included details of the patients preferences for treatment and decisions. Staff at the practice told us copies of the care plans were kept in their homes. Some of the patients we spoke with confirmed this.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical and non-clinical staff demonstrated a clear understanding of Gillick competencies. (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

It was practice policy to offer an annual health check to all new patients registering with the practice and patients aged 75 years or over. The practice offered three yearly NHS

Good

Are services effective?

(for example, treatment is effective)

Health Checks to all its patients aged between 40 – 74 years who were not already diagnosed with diabetes, heart disease, and stroke or kidney disease. These checks included a cholesterol test, blood pressure check, weight and lifestyle management advice. The GP was informed of all health concerns detected and these were followed up in a timely way. We saw notices in the waiting room that made patients aware that these health checks were available.

The practice actively engaged their patients in lifestyle programmes as they were aware that they had a high number of patients who needed this support. Smoking and obesity rates were currently similar within the practice at approximately 32%. Practice nurses described to us how they sign posted patients to weight loss clinics and completed exercise referrals for patients who needed to manage their weight.

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations. The practice offered travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was performing above national standards in providing flu immunisations for the target groups of patients.

There were systems in place to support the early identification of cancers. Information we reviewed showed that the rates of emergency admission for cancer patients had decreased over the past three years. This had fallen from 13.3% to 6.4% (Per 100 patients) as compared to the CCG average of 33.5% to 8.9% over the same period. The practice carried out cervical screening for women between the ages of 25 and 64 years. Patients who did not attend for cervical smears were offered various reminders, by telephone and letters for example and the practice audited non-attenders annually. The practice offered Chlamydia screening service to all 16 – 24 year olds as they presented at the practice. Family planning services were provided by the practice.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept registers of their patients who would be considered at risk and or vulnerable. These included a register of patients with learning disabilities, and a register of all patients with mental health problems. These patients received an annual physical health check by the practice. The practice had completed the care plans for all these patients.

We saw that up to date health promotion information was displayed, available and easily accessible to patients' in the waiting area of the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in 2014. The results of this survey showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who described their experience of the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them and 81% saying the GP gave them enough time.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 27 completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. During our inspection we observed the interaction between staff and patients within the reception area. This included interaction both in person and over the telephone. We saw that staff were helpful, compassionate, dignified and respectful towards patients. They said staff treated them with dignity and respect. We also spoke with 19 patients all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments related to population groups told us that continuity of care was provided for patients experiencing poor mental health, and good care was provided for children and patients with long term conditions.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Patients told us that although difficult at times staff were always mindful of confidentiality at the reception. Information in the 2014 national patient survey showed that 54% of patients were satisfied with the level of privacy when speaking at the reception desk. The practice had put measures in place to address this. A visible notice requested patients to stand further away when receptionists were talking to patients at the reception desk. A room was also made available if patients wanted to have a private discussion. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms to ensure that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us that 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 and on the practice website stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

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 2014 national GP patient survey showed 71% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining their treatment and results. Both these results were above average compared to CCG national levels.

Patients we spoke with at the inspection told us that they were involved in decisions about their care. We found that older patients, patients with long term conditions and those experiencing poor mental health were aware of the practices involvement in supporting patients to avoid hospital admissions. They told us that they had been involved in planning their care to support this initiative. One patient explained how the systems for their care and medicine reviews worked. There was evidence of care plans and patient involvement in agreeing to these for older people and people with long-term conditions. Patients with long term conditions told us that their care was reviewed annually or more often if required.

Good

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and that they felt involved in decision making about the care and treatment they received. Patients were given information in the form of leaflets and telephone numbers of organisations that could offer them support related to helping them to manage their condition. Patients told us that they did not feel rushed at their appointments.

Patients told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients were told how long it would be before their test results were received by the practice. Patients were made aware that it was their responsibility to check their results and make an appointment to discuss them with the doctor if advised to do so. Patients were reminded that test results could only be released to the person to whom they relate or someone who had been given prior permission in keeping with confidentiality and data protection guidance. Following an incident related to the late feedback of test results, the system for ensuring that results were shared with patients in a timely way had been reviewed and improved.

We saw evidence that children and young people were treated in an age-appropriate way and recognised as individuals with their preferences considered.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Information for carers and families that had suffered a bereavement was also available in care packs and leaflets in the waiting room of the practice.

The patients we spoke with on the day of our inspection and the comment cards we received told us that staff responded compassionately when they needed help and provided appropriate support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that practice staff showed a good understanding and knowledge of their patients. We saw that the practice was responsive to their needs and had systems in place to maintain the level of service provided. For example, longer appointments were available for people who needed them. This included patients experiencing poor mental health and patients with long-term conditions. Home visits were available and provided at the discretion of GPs and advanced nurse practitioners' based on clinical need.

To support the diverse needs of vulnerable patients the practice worked closely with various groups of locality based services and professionals. These included health visitors, social services, the learning disability team and the police. The practice had close links with these groups and was able to make appropriate referrals and signpost patients to appropriate professionals and support services that could help them. The advance nurse practitioners had received training and had the necessary skills to support the needs of patients that misused substances and patients who were homeless.

Registers had been developed to identify patients with learning disabilities, long term conditions, such as diabetes and arthritis and patients who received palliative care. We found there was a recall and annual review system in place for patients with long-term conditions such as diabetes and respiratory disease. The practice had completed care plans for all their patients diagnosed with dementia and those experiencing a mental health illness. The active identification and management of patients with dementia patients had resulted in reduced emergency admissions to hospital, 2.9% per 100 patients in 2013 – 2014 as compared to 5.9% in 2011 – 2012.

The practice carried out a weekly visit to a dementia care home where a number of older patients registered with the practice lived. At this time they reviewed all their patients with the support of the care home staff. The GPs and advanced nurse practitioners also provided support to known homeless patients and patients that misused substances. A weekly addiction clinic was offered at the practice by a local community service for patients who misused drugs. This was carried out in conjunction with the lead GP for this area. A formal review of each patient was carried out every three months by the GP. Staff had attended training to support them in these roles.

The practice had an active website which offered patients the opportunity to make online appointments or access to an online repeat prescription service. Some of the patients we spoke with told us, that the repeat prescription service worked well at the practice. This was also confirmed in comments we received, which included feedback from working age patients.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had an active 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. For example in 2013 the PPG was involved in two focussed survey's looking at whether patient's understood their care and treatment for specific illnesses. One of the surveys looked at patients with Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases which could include chronic bronchitis, emphysema or both. One of the conclusions of the survey was that a review of the 'Self Care Management Plan' was needed based on patients concerns regarding its format. The practice had taken this forward as part of their 'Self Care Champion Project'.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services were situated in a purpose built building designed to meet the needs of all patients. For example automatic doors and provided easy access to patients with disabilities and parents with pushchairs. The practice was situated on the ground floor of the building with all services for patients on this floor.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A loop system is installed at the reception desk and there is also limited availability of a portable loop system that can be used in consulting rooms for patients who have a hearing impairment. Patients with a visual impairment had access to a braille translation service, the RNID Typetalk service. Information for the visually impaired was produced on yellow paper and in large font.

The practice kept a register of patients who may be living in vulnerable circumstances. There was a system for flagging vulnerability in individual records, and patients were easily able to register with the practice.

Access to the service

Appointments were available from 8.15am to 12pm and 2pm to 6pm on weekdays. The time varied slightly on Tuesdays when the practice was closed between 12:00pm and 2:30pm for essential staff training. Patients were made aware of these appointment times through posters in the waiting area, information in the practice leaflet and on the practice website. For older people and people with long-term conditions both home visits and longer appointment times were available when needed. For families, children and young people there were appointments available outside of school hours.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. For example patients were told to call the practice as soon as possible after 8am if they needed to be seen the same day and no later than 10:30am. Patients were advised that the practice were unable to make same day appointments after this time unless their medical need was urgent.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Notices in the waiting area made patients of what to do when the practice was closed.

Due to the restrictions of the opening times of the building staff were unable to offer extended hours at Moss Green Surgery. To overcome this the practice offered extended opening hours at the practice owned by the partners (Moorcroft Medical Centre) situated in the Hanley area of Stoke on Trent. Early morning appointments were offered from 7.30am and later evening appointments until 7.20pm. This was particularly useful to patients with work commitments. The practice also offered Saturday morning clinics for patients registered at Moss Green Surgery at its Moorcroft Medical Centre. These were offered between November 2014 and March 2015 as part of the 'Winter Pressures Scheme'.

Patients were generally satisfied with the appointment system. Information from the 2014 GP survey showed that 91% of patients found it easy to get through to the practice by phone compared to the CCG average of 72% and 88% of patients described their experience of making an appointment as good compared to the local CCG average of 77%. They also said 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.

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.

We saw that information packs were available to help patients understand the complaints system. We saw that information was also available in the waiting room, in the patient information leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. Patients felt that if they had to make a complaint they would be listened to and their complaint dealt with promptly.

We looked at four complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. We found that complainants were spoken with or written to, to discuss their concerns and a final letter sent detailing the outcome of the practice investigation. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw that all the complaints were related to

Good

Are services responsive to people's needs?

(for example, to feedback?)

the appropriateness of treatment. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. Lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed at the practice and on the practice website. The practice vision and values included to ensure high quality safe and effective services and to create a partnership between patients and health professionals which ensures mutual respect, holistic care and continuous learning. We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice also planned to recruit, retain and develop a highly motivated and appropriately skilled workforce. At the beginning of 2014 the practice had identified that their GP workforce had decreased by 37% within a six month period. They dealt with this as a significant event and carried out an analysis of the reasons for GPs leaving. These reasons included health, workload, stress and professional isolation. The practice used these responses to formulate an action plan. Changes implemented included, successful recruitment of a new partner, salaried and sessional GPs, introducing a senior clinical team, expanding the role of advanced nurse practitioners and daily 30 minute clinical meetings. The practice had also recruited an advanced prescribing pharmacist.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at 10 of these policies and procedures. These included complaints, recruitment, whistleblowing, safeguarding and infection control. We saw that the policies were not dated to reflect the date they were reviewed and by whom.

Staff at the practice took specific leadership roles. For example one of the partners took responsibility for managing patient information and was the 'Caldicott Guardian'. Information governance is the term used to describe how organisations manage the way information is handled within the health and social care system. It covers the requirements and standards that practices need to achieve to fulfil their obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust. We spoke with 12 members of staff 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 used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing in line with national standards with a practice value of 90.2% compared with a national value of 92.3%. We saw that QOF data was regularly discussed at monthly governance meetings. We saw that actions had been taken to maintain or improve patient outcomes. These included a review of the guidelines for prescribing certain antibiotics and an action plan to review how patients with chronic kidney disease were managed.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, two audit cycles were completed to review antibiotic prescribing related to five infection related conditions these included tonsillitis, middle ear infections and pneumonia. Both audits looked at best practice in each area and each audited area was then reviewed against this and action to be taken discussed and agreed. The first audit was carried out in December 2013 and the second cycle November 2014. After two cycles of this audit the practice were able to demonstrate that there had been some improvement clinicians needed to ensure that they followed the guidelines or documented their reason for giving alternative treatment.

The practice had arrangements for identifying, recording and managing risks. The practice manager had developed a risk log which identified the level of impact each risk posed to the practice, a risk lead, a plan of action and a review date. We saw that this was integrated into the practice's three year business plan.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an

Are services well-led?

Good

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

open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that the practice held regular learning and team sessions as required. These included on and off site events and occurred at times that were appropriate and convenient to meet the needs of staff and the practice.

We saw from records and speaking with practice staff and external staff attached to the practice that the practice had an open culture and that all staff were encouraged to raise issues. We saw that when a member of staff had needed to raise a concern, they had been supported to do so, in line with staff management policies. We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities.

The practice had developed a strong management administration team and one of the managers was a managing partner. The team covered the management of finance, practice management and information technology. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through for example, patient surveys and complaints received. We looked at the results of the practice annual patient survey for 2013-2014. We saw that the practice was encouraged that following actions taken during 2012-2013 that the results of this survey showed that improvements had been made. For example, the results for patients seeing a GP of their choice in 2012-2013 was 49% compared to a national average of 55%. The response for this question in the 2013-2014 survey showed an increase to 72% compared to a national average of 62%.

The practice had an active patient participation group (PPG) which was steadily increasing in size. The PPG was not representative of the practice population in terms of gender, age and ethnic background. The practice was actively working on building a PPG group that included representatives from their various population groups. There was an even distribution of representatives within the 45 – 75 age groups, 10% within the 25 – 34 age group and members of the group (70%) were mainly female. The PPG had carried out surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG.

The practice had gathered feedback from staff through annual appraisals, regular formal meetings and informal daily contact. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available electronically on any computer or as a paper document 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. Staff files we looked at demonstrated that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended.

The practice was a GP training practice and also accredited to provide training for medical students. We found that there was a supportive GP buddying system in place for GP trainees at the practice. This system provided the GP registrars with direct access to GP support each day. The GP registrars also had their own syndicate and attended a monthly forum for networking and to share experiences. We saw that there was also a buddying system for nurses and this role was fulfilled by one of the GPs.

The practice had also identified from their annual patient survey carried out in 2013 – 2014 that the results showed an overall downward trend in the patient consultation experience at Moss Green Surgery. The findings were discussed with PPG who noted that this was disappointing. The practice agreed to look at this in detail and identify any trends that could help to improve the patients' experience.