Market Square Surgery

Quality Report

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Date of inspection visit: 24 October 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

On 24 October 2014 we carried out an announced comprehensive inspection of Market Square Surgery, Waltham Abbey, Essex under our new approach of inspection of primary medical services.

We found that the practice was good across all the key areas we looked at and patients expressed a high level of satisfaction about the way the services were provided.

Our key findings were as follows:

- The practice had systems and processes in place that made the practice safe for both patients and staff.
- Staff were kind and caring and dedicated to providing high quality care and treatment. Patients privacy and dignity was maintained.
- The practice were aware of the needs of their patients and tailored services to meet them
- The practice worked well with other health care providers to achieve effective outcomes for their patients. Information sharing and communication with partner agencies helped support the levels of care and treatment received by patients.

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

The provider should:

- The practice should undertake a Health and Safety Risk Assessment to ensure staff and patients are safe.
- The practice should ensure staff are suitably trained in fire emergency procedures and that fire drills are practised at appropriate intervals.
- The practice should review their repeat prescription system to ensure patients receive a regular review of their medicines.

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?

The practice is rated as good for safe. The practice had systems in place that demonstrated they were a safe practice and had sustained this over time but some improvements were required. Sufficient numbers of staff had been trained in safeguarding children and vulnerable adults and whistle blowing and all were aware of the different signs of abuse. A safeguarding lead had been appointed who had been suitably trained. Where any safety issue had been identified or reported, they had been investigated and areas for improvement identified. Team meetings and other formal notifications to staff ensured they were aware of any learning to prevent a reoccurrence. Staffing levels were monitored, processes were in place to manage emergencies and infection control procedures were satisfactory. Fire procedures required reviewing in conjunction with other users of the building. The recruitment procedure was not clear about which roles required Disclosure and Barring Service checks. There was an absence of a Health and Safety Risk Assessment to keep staff and patients safe.

Are services effective?

The practice is rated as good for effective. Patients had their needs assessed in line with published guidance and the practice worked closely with other health care providers to achieve effective outcomes for patients. An effective system was in place to refer patients to specialists and recordswere updated with the outcomes of those consultations. Health care promotion took place through health checks and the provision of information to help people live healthier lives or manage their conditions. Patient reviews took place to ensure treatment and medicines were effective. Staff understood consent requirements and supported patients when necessary. Staff received appraisals, development opportunities and were supported in the workplace. Performance across key health care objectives were being monitored regularly to ensure the patient population received the best outcomes.

Are services caring?

The practice is rated as good for caring. Patients were satisfied with the way they were treated and thought staff were kind and caring. Privacy and dignity was respected and patient confidentiality maintained. Patients received clear explanations from clinical staff and were involved in their care and treatment. Where care plans

Summary of findings

were required, these had been discussed with the patient and their relatives, if applicable. A range of health care literature was available in reception and on the practice website which provided information for patients and signposted them to support services.

Are services responsive to people's needs?

The practice is rated as good for responsive. Patients told us that appointments were readily available but that on some occasions it was difficult to get an appointment time of their choice. Where there was an urgent need, they could see a GP, receive a home visit or phone consultation on the same day. Older patients had a named GP who had responsibility for the oversight and coordination of their care. Patients could see their preferred GP when they were available and had a choice of a male or female doctor. An effective complaints system was in place, understood by all staff and learning opportunities were identified and acted upon. Information was available to patients in leaflet form at reception. The practice was readily accessible to patients who had a disability or those with limited mobility.

Are services well-led?

The practice is rated as good for well-led. A clear leadership structure was in place and designated leads had been identified for key roles. All staff were aware of their individual responsibilities. Audits had been undertaken to monitor and assess the quality of the services provided and staff and patients were asked for feedback about the way the practice was managed. Regular staff meetings took place. Where areas for improvement had been identified these were followed up with an action plan and then monitored until completion.

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 older people. Patients over 75 had a named GP who was responsible for the oversight and coordination of their care. Care plans were in place for older people with complex needs. GPs and other health care professionals worked together in a multi-disciplinary way to provide the best care and treatment and to reduce unplanned hospital admissions. Care and treatment was personalised and met the needs of older people. Dementia screening took place to try and identify those patients showing signs of the illness so they could be referred to specialists early to enable them to receive support and treatment to help them manage the condition. The appointment system reflected the needs of the elderly. Telephone consultations and home visits were available if necessary and older patients were given priority. An effective flu vaccination programme was in place.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions. Patients with long-term conditions received regular health checks from a GP and were offered and signposted to support organisations to help them manage and understand their condition. Appointments with the nurse and health care assistant were readily available so that patients could be monitored. The practice worked with other health care providers for patients with complex needs through a multi-agency approach and regular meetings.

Families, children and young people

Good

The practice is rated as good for families, children and young people. There was an effective system in place to safeguard children from abuse through the use of a register identifying vulnerable patients. Staff had been trained in safeguarding and were able to identify the different signs of abuse. Mothers and babies could access postnatal and antenatal support from the Nurse and Health Care Assistants. The practice followed immunisation guidance for young babies and children and these were effective. Young people were able to book appointments without a parent being present, subject to satisfying GPs of their ability to understand the care and treatment suggested.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people. The appointment system met the needs of these patients. A late evening

Summary of findings

surgery was available one day each week for working people or those who could not attend during the day. Daytime appointments could be booked on the same day or the next day. The practiced promoted healthy living and appointments were available with the practice nurse for lifestyle advice. This included smoking cessation and alcohol advice designed to prevent ill health in the future. The student population was encouraged to register at the practice as temporary residents.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. A register was maintained of patients with learning disabilities and they were invited to attend an annual review or more frequently if considered necessary. A double appointment was made available to them to ensure their needs were covered. Carers of those living in vulnerable circumstances were identified and offered support including signposting them to external agencies. The practice had a travelling community nearby and a number of refugees as patients. Information and registration packs were available for these groups when registering at the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health. A nurse trained in mental health worked at the practice for one day each week. Suitable patients were referred to her for support and counselling. Timely referrals were made to specialists after a dementia diagnosis so early medical intervention could be achieved. Patients who were diagnosed with dementia were then included on a register and their condition monitored after discharge from a specialist.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete about their views of the practice. We collected 37 cards that had been left for us and reviewed the comments made. We also spoke with a number of patients on the day of the inspection to seek their views about the practice.

Patients were very complimentary about the GPs, the nurses, health care assistant and the reception and administration staff. Areas that were praised included the kindness in the way care and treatment was provided by the GPs, politeness of the reception staff, the explanations about care and treatment options, the advice and support received, appointment availability and the cleanliness of the practice.

There were also encouraging comments about the support received from the mental health counselling service provided by the practice and how it had produced positive outcomes for patients. Only two minor negative comments were received relating to the availability of appointments, but improvements had been recognised.

The practice had undertaken a patient survey in January 2014. Patients were asked to complete a questionnaire about the services provided including the appointment system, the quality of the GP consultations and explanations about care and treatment. The survey also included other health care professionals who answered questions about their inter-action with the GPs at the practice and their views on their clinical skills.

The results of the survey revealed that there was a high satisfaction rate amongst patients and other health care professionals. As a result of the survey, GPs completed a reflection document which acknowledged their own personal improvement areas and how they would set about achieving them. This was the subject of review after the next survey due in 2015.

Areas for improvement

Action the service SHOULD take to improve

The practice should undertake a Health and Safety Risk Assessment, to assess the risks to patients and staff.

The practice should ensure staff are suitably trained in fire emergency procedures and that fire drills are practised at appropriate intervals.

The practice should review their repeat prescription system to ensure patients receive a regular review of their medicines.

Market Square Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied a GP Specialist Advisor**.**

Background to Market Square Surgery

Market Square Surgery is situated in Waltham Abbey Essex and is one of 38 GP practices in the West Essex Clinical Commissioning Group (CCG) area. The practice is accessible by public transport and Waltham Cross railway station is approximately four miles away. The practice has a General Medical Services (GMS) contract with the NHS. There are approximately 6180 patients registered at the practice

The practice is located in a health centre shared by two other separately registered GP practices, in a building not owned by them. There is limited parking available outside the front of the premises but use can be made of free all day parking in a nearby car park where there are parking spaces for the disabled.

The reception area in the main entrance is shared with other users of the health centre but patients attending for the Market Square Surgery have a dedicated desk allocated to them. The waiting area is very spacious and also shared by those attending the health centre.

The practice has two full time and one part-time GPs, two of whom are male and one female. There is one female nurse practitioner supported by a health care assistant.

One additional nurse works one day a week for the purpose of counselling patients with mental health issues. There are four reception and administration staff who have responsibility for a variety of roles.

GP sessions take place each weekday in the mornings and afternoons and on Thursdays surgery hours are extended to 8pm. There are appointments available to see the nursing staff on each day of the week. The practice is closed at weekends.

The practice have opted out of providing out-of-hours services to their own patients and make use of the emergency 111 service.

The practice has been selected for inspection as part of our new comprehensive inspection programme and at the time of the inspection there were no known concerns. The CCG and other organisations we consulted with prior to our inspection did not provide us with any data to suggest that there are any issues affecting the performance of the practice.

Why we carried out this inspection

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

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

Detailed findings

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. Two weeks prior to the inspection, we left comment cards for patients to complete, to provide a view of their experience of the services provided. We reviewed these subsequently.

We then carried out an announced visit on 24 October 2014.

During our inspection we spoke with two GPs, the practice manager, nursing staff and members of the reception and administration staff. We also spoke with patients who used the service. We observed how people were spoken with by staff and reviewed policies, protocols and other documents used at the practice.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice monitored patient safety using a range of different sources including significant events analysis, complaints, national patient safety alerts and a safeguarding adults and children register. Staff were aware of the systems in place for recording such incidents and were encouraged to bring them to the attention of the practice manager.

On the day of our inspection we reviewed several of the significant events that had taken place in the last 12 months and found that they had been analysed effectively. Where learning had been identified this had been cascaded at staff meetings or through informal discussions and recorded in writing. Staff spoken with displayed an awareness of the significant events and the outcomes.

National patient safety and medicines alerts were handled effectively and actioned where appropriate to ensure patients were safe. On receipt of any such information, it was recorded and clinical team members notified.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, including accidents in the workplace. All staff were aware of it and encouraged to report any incident, regardless of how minor it might appear to be. Records we viewed reflected that incidents had been recorded correctly, investigated and where areas for improvement had been identified, these were cascaded to staff appropriately.

One such example we viewed involved over prescribing medicines to a patient that resulted in a cost issue for the practice rather than a safety issue. An analysis took place followed by a change in prescribing practice that saved costs and reduced waste of unused medicines.

National patient safety and medication alerts were received by email and a member of staff had been allocated responsibility for them. A system was in place to notify relevant clinical and administration staff either by email or written memorandum, which had to be acknowledged and monitored to ensure all staff had read it. Where required, action was taken to review patients care and treatment. This ensured patients were safe and received the most appropriate care and treatment based on research and guidance.

We looked at the minutes of the significant events analysis and staff meetings and found that safety issues had been discussed and areas for improvement cascaded. On speaking with staff at the practice, we found they had been made aware of the learning from significant events and complaints, either at team meetings or formal written note.

Reliable safety systems and processes including safeguarding

The practice had appointed a dedicated GP safeguarding lead for vulnerable adults and children who had received appropriate training to carry out the role. A register of vulnerable adults was maintained and monitored. The practice operated a computerised patient record system and where a patient was identified as being at risk, an entry was placed on their record so they could be monitored and reviewed when attending for appointments.

Children at risk of abuse were placed on an 'at risk' register which was regularly monitored. The computerised record system was updated so that when attending for an appointment, the GP or nurse was notified of the 'at risk' status of the patient.

For both vulnerable adults and children at risk, a close relationship was maintained with other agencies who discussed and referred relevant cases to the practice. We found that a multi-agency approach was adopted and saw that input was received from school nurses, midwives and other specialists.

All staff displayed an awareness of safeguarding procedures in relation to vulnerable adults and children. They knew the different signs of abuse and the reporting process. All staff had received safeguarding training. An example was provided to us where a member of staff had noticed an issue and had brought it to the attention of the relevant person. This was then passed to the local authority for formal investigation.

Staff were able to display a working knowledge of whistleblowing procedures and felt confident that any concerns they raised would be dealt with in a professional way without fear of recrimination.

Good

Are services safe?

The local authority safeguarding protocol was readily available in reception so staff could refer to it whenever required. This highlighted the correct procedures to follow, who to contact for advice and how to make a referral.

We found that staff had been trained in clinical practices that followed recognised guidance and kept people safe. Correct procedures were being used for patient vaccinations; including ensuring sterilisation procedures were being followed. Prior to giving vaccinations, patient records were checked to establish whether a patient was due to receive one.

Patients were able to have a chaperone present during appointments with the GPs or nurse and signs were available in reception advising them of this facility. A chaperone policy and protocol was in place and available for staff to read.

Some staff had received formal training but one staff member told us that whilst present at consultations as a chaperone, they did not stand inside the curtain to observe the examination. We have discussed this with the practice who has agreed to clarify the role of the chaperone with all staff to ensure they stand inside the curtain, which is in line with recommended practice.

The computerised system had a panic alarm setting which staff could use to summon assistance if a problem occurred. On activating this alarm, it alerted other reception and other staff to the problem and identified the room concerned. Staff could then attend and provide assistance.

Medicines Management

Medicines in use were stored in line with relevant guidance and only accessible to authorised staff. Each GP had their own emergency drugs bag that they took with them to their consultations with patients. All drugs were in date and a system was in place to check them regularly.

We found that the practice monitored its prescribing data and was aware of their performance in this area. A monthly meeting took place attended by a pharmacist from the Clinical Commissioning Group. This had resulted in better monitoring of prescribing patterns and reductions in costs had been seen without reducing the outcomes for patients. Medicines were also monitored to ensure that where known risks were present, less risky alternatives were offered to patients to achieve the same health outcomes.

Vaccines were administered by GPs and the nurse practitioner in line with recommended guidelines. Two fridges were in use at the practice, one that contained medicines ready for use and the other stock storage purposes. We checked the medicines in both fridges and found them to be in date and a system was in use for the monitoring of expiry dates and stock rotation. Temperatures were being monitored and recorded and were in acceptable ranges.

A system was in place to review repeat prescriptions and whether a medicine review was due. The computerised system produced a date for reviews and prescriptions were not signed by the GP until one had been arranged. Patients were informed that this was a requirement before issuing the prescription.

However, on the day of our inspection, we spoke with one patient who had collected their repeat prescription. We found that despite the system in place, the prescription had been issued over a year beyond the date that the review was showing as due. We recognise that this may have been an administration error but recommend that the process for repeat prescriptions be analysed to ensure that reviews are taking place and records updated correctly. The practice has agreed to look into this.

Cleanliness & Infection Control

The practice had an infection control policy that covered a range of topics such as cleanliness, hand washing guidance, spillage handling, training for new and current staff and the disposal of clinical waste. The policy had been reviewed in October 2014. There were also Control of Substances Hazardous to Health (COSHH) guidelines in relation to the safe and effective use of cleaning materials. An infection control lead had been identified to assume responsibility for managing and minimising the risk of patients and staff contracting a health care related infection.

The practice had undertaken an infection control audit, also in October 2014 and where areas for improvement had been identified, an action plan had been put in place to achieve the improvements.

Checklists were in place to ensure that the cleaning was effective and these stipulated the areas to clean and the frequency. Records we viewed reflected that cleaning schedules were being followed.

Good

Are services safe?

At the time of our inspection, most of the cleaning at the building and the practice was undertaken by a cleaning company contracted by the owners of the building, rather than the practice. One of the staff at the practice was responsible for checking the cleaning quality and a checklist was being completed to ensure standards were maintained. A system was in place to replace any broken or defective items.

Staff were able to demonstrate the correct procedures when using the consultation room designated for undertaking minor procedures such as the removal of sutures (stitches). Personal protective equipment (PPE) was readily available and used. This included disposable gloves and aprons. Patient couches were cleaned between each use with alcohol wipes and separate bins were available for clinical waste, which was stored and disposed of in line with recognised guidelines. The sinks in use complied with good practice and a schedule was in place to clean the privacy curtains around the couches, every six months.

Although we were satisfied that the treatment room was visibly clean and hygienic no records were kept by the nurse who was responsible for this room. The practice have acknowledged this and will start keeping records in the near future.

Staff were protected against blood borne viruses such as hepatitis B and their immunisation levels were regularly tested to ensure they were protected.

Sharps bins, used for the storage of used needles, were signed, dated, stored correctly and not overfilled. Correct procedures were being followed to dispose of them safely. Staff were aware of the procedures to follow for a needlestick injury and a written procedure was in place that described the action to take. This would then be recorded and learning identified to keep staff and patients safe in the future.

Spillage kits were available for staff to use in the event of blood or other bodily fluids needing to be cleared up. These were stored securely and staff knew their location. There was an adequate supply of PPE available to protect staff from the risk of infection.

The practice had sufficient numbers of trained staff in infection control and they received annual training. New members of staff received induction training in infection control procedures

We found that the premises was visibly clean and tidy throughout. There were hand washing signs in staff and patient toilets and a ready supply of wall mounted hand gels and paper towels. Patients told us that the practice was always clean and tidy and that staff used appropriate personal protective equipment when necessary whilst undertaking consultations and examinations.

A sign was also present in the reception area encouraging patients who noticed a cleaning issue, to contact staff at reception.

The systems in use at the practice were effective in protecting patients and staff from a health care related infection.

Equipment

Equipment in use at the practice was in sufficient quantities to meet the needs of patients and checked and calibrated regularly. Records held reflected that it was all in working order. All electrical devices were subject to an annual portable appliance test (PAT). Staff we spoke with were satisfied that the practice had the most appropriate equipment and in sufficient quantities, to enable them to carry out examinations, assessments and treatments that kept patients safe.

Oxygen was available if required and a mask available for use by a patient. These were both in date and staff were able to demonstrate their use correctly.

Staffing & Recruitment

Staffing levels were monitored at the practice and periods of annual leave, sickness, training or other absence covered in advance. A named person at the practice was responsible for monitoring staff levels with support and guidance from the GPs. On most occasions staff were able to cover for each other and where this was not the case external staff were sought. This was often from the two other practices working in the same health centre where a reciprocal arrangement was in place to support each other. When necessary schedules were re-arranged so that patients were not inconvenienced.

Locum GPs were used when the permanent GPs were unable to run surgeries. Their use was planned in advance so that sufficient numbers of GPs were always available. A system was in place to check the qualifications and

Good

Are services safe?

experience of locum GPs and their General Medical Council registration although this was not formally recorded. The practice has agreed to formalise this process in the near future.

Staff told us that staffing levels were satisfactory and cover was always available. Patients we spoke with said that they were satisfied with the numbers of staff available at the practice and that they seemed qualified and experienced to carry out their role.

A recruitment policy was in place that identified the procedures to follow when employing new members of staff. This included proof of identity, checks of qualifications and experience, registration with their professional body and suitable references. New staff were also given a training needs assessment form to complete to help identify training needs. Recently, staff with employment responsibilities attended 'Safer Recruitment' training so they were up to date with current guidelines.

We noted that the recruitment policy did not reflect when a Disclosure and Barring Service (DBS) check would be required for new staff, either clinical or non-clinical, or a written criteria or risk assessment if it was decided that one was not required. The practice has agreed to review the staff roles to reflect which ones require a DBS check.

We looked at a number of staff records to ensure that the recruitment policy was being followed and to check that relevant employment documentation had been provided. We found that procedures were effective. Qualifications for staff had been verified and registration with their professional bodies confirmed. DBS checks were current in relation to the clinical staff working there.

Monitoring Safety & Responding to Risk

The practice had identified a Health and Safety lead, who was the Practice Manager. The practice had a Health and Safety policy that was accessible to all staff. The practice did not have a Health and Safety Risk Assessment in place that identified the risks to staff and patients attending the health centre. This is a legal requirement under the Management of Health and Safety at Work Regulations 1999.

The practice monitored and responded to risks to patients and staff through other systems, policies and procedures. These included an infection control audit, cleaning schedules, medicines management, hepatitis B monitoring of staff and the way they dealt with emergencies.

Staff meetings were minuted and where there were safety issues, these were discussed with all staff at the practice. The minutes we viewed reflected this was common practise and staff were aware of the issues that had been raised in the past.

Patients were monitored to identify changing risks to their health or the medicines they were taking. Reviews took place regularly and patient safety and medicines alerts were responded to, changing the treatment where required, to keep patients safe.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan that had been reviewed and was up to date. It was readily available in hard copy or computerised. Staff were aware of its contents and the action to take in an emergency that prevented services being available for patients.

The document detailed the steps to take if in the event of such an emergency. It covered such eventualities as failure of the electricity supply, an illness pandemic, severe weather conditions and explained how to obtain alternative accommodation.

All staff had been trained in basic life support and training certificates were viewed confirming this in staff files. Emergency medicines and equipment were readily available and accessible to staff members and all knew where they were located. Medication and other equipment were all in date and there was an effective system in place to monitor stock and expiry dates. Records were kept for this purpose. Oxygen was also available and in working order.

As the premises were shared with other health care providers, some of the environmental safety checks undertaken to keep staff and patients safe, were dealt with by the company responsible for the buildings maintenance at the location. We looked at the records held for these checks and found that since August 2014, action had not been taken to replace broken items that had been damaged.

Good

Are services safe?

We also found that the practice did not undertake fire drills but fire alarm testing did take place weekly. We recognised that the building was jointly occupied by several practices and that any evacuation as a result of fire or other emergency may have impacted on all users of the building.

However we were not assured that the practice had a fire evacuation procedure that kept people safe. The practice has agreed to look into this and make improvements. However fire extinguishers were in date and there was a regular system in place for checking them.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nursing staff on the day of our inspection and were satisfied that care and treatment was being delivered in line with best practice and legislation. They were aware of the guidance provided by the National Institute for Health and Care Excellence (NICE) and how to access the guidelines and updates. There was an effective system in place to monitor national patient safety and medicine alerts. This ensured patients received effective consultations and treatment.

The Practice Nurse took a lead role in relation to conditions such as child immunisations, diabetes, heart disease and asthma and patients with these conditions were seen and monitored. Data held in relation to the performance of the practice reflected that they were achieving their performance targets and these were the subject of regular monitoring. Patients requiring seasonal flu vaccinations were contacted in a pro-active way and encouraged to attend.

Patients with long term conditions and those approaching the end of their life through illness, had their needs assessed and were provided with effective care and treatment. Regular multi-disciplinary meetings took place with other health care professionals to review their needs and tailor the care and treatment required on an individual basis.

We spoke with the carer of a patient on the day of our inspection. They told us that they had received a consultation that day and that it was effective. A care plan had been put in place and this had been updated when recent deterioration had been noticed. They spoke highly of the care assessment they had received and said that explanations of treatment options were clear. They had also been offered support from external agencies and other health care professionals.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a national performance measurement tool that details GP practice achievement results. It is a voluntary programme that this practice has chosen to use. It is linked to managing some of the most chronic diseases, implementing preventative measures, offering extra services and providing quality health care services. Through the monitoring of their computerised patient record system, the practice could monitor their effectiveness in providing these services to improve health care.

The practice undertook regular monitoring of their performance in the QOF and this was reviewed regularly by staff working at the practice. This ensured they were on target to achieve positive outcomes for their patients and were aware of the targets they were expected to achieve. These targets included diabetes monitoring, seasonal flu and child vaccination programmes, cervical screening and prescribing monitoring.

We looked at the data available to us about this practice. We found that they were better than average nationally in dementia diagnosing rates, maintaining a register and monitoring patients with learning disabilities and those with palliative care needs and the preparation of detailed care plans for patients needing them. All other areas subject of monitoring reflected that they met the national average for performance.

Child immunisation data was also available. This is a national immunisation programme. This reflected that the practice performance exceeded 90% across all areas, in relation to the provision of childhood vaccinations for those from birth and up to under five years of age.

On the day of our inspection we looked at several clinical audits that the practice had undertaken to monitor and assess the services they provided. An analysis of the findings had taken place and where areas for improvements were identified these had been documented.

Effective staffing

The GPs we spoke with on the day of our inspection had received an annual appraisal and had been given dates for their revalidation. The revalidation process takes place every five years and involves a more detailed assessment of their competence. Only when revalidation has been confirmed by NHS England can the GP continue to practice. One of the GPs had recently undertaken some self-development and qualified as a trainer of GPs and in the near future would mentor trainee GPs.

The practice used an externally acquired appraisal toolkit to assess the performance of the GPs working at the

Good

Are services effective?

(for example, treatment is effective)

practice during 2014. This enabled them to receive feedback from their own GP colleagues, other health care professionals and from patients or their parents/guardians who attended the practice. All were required to complete a questionnaire covering a range of topics, followed by an analysis of the results.

The GPs were then presented with the results to see where improvements might be made about their performance. They then produced a short document reflecting on the comments they had received, where they might improve and how they would go about it.

Staff we spoke with told us they felt supported and were provided with opportunities for development through the appraisal process. We saw examples of where staff had been encouraged to develop themselves and to receive additional training to help them carry out their role. This included computer courses and training to become a Health Care Assistant.

When an annual appraisal was due, staff were invited to complete a training needs assessment form to indicate what training they might need, to improve their competency levels. It was then considered and provided if it met the needs of patients. Some examples of this were vaccination training, wound care courses and how to provide smoking cessation advice. Clinical staff had also received training in the use of electro cardiograms (ECGs) used to monitor the electrical output of the heart and this test was now available at the practice.

All staff had received an appraisal. Staff we spoke with felt they were performing to a satisfactory standard but confirmed that this was not being recorded in their appraisal form. They all felt supported at the practice and said that it was a nice place to work. Nursing staff were supported to undertake their continuous professional development (CPD) to maintain their skills.

All staff, including those working on reception had received training in relation to whistle blowing and safeguarding vulnerable adults and children. GPs and the practice manager had received additional training in other types of abuse and the signs to look out for.

All staff had received basic life support training from a recognised training organisation that attended the practice and trained staff on site. A review of the frequency of this training had taken place recently and it had been decided to hold refresher training every 12 months for clinical staff instead of every 18 months. Staff training was being effectively monitored.

The practice manager told us that they were supported at the practice and had the benefit of calling on the assistance of the other practice managers working in the same building if they needed advice. They also received an appraisal from one of the GPs.

The staff files we viewed reflected that staff had the right qualifications, skills, knowledge and experience to deliver effective care and treatment. An induction process was in place for new members of staff who were not permitted to work on their own until they had satisfied a supervisor that they were competent to do so. New staff were mentored and supported to achieve the required standards. Staff were clear about their roles and responsibilities.

Working with colleagues and other services

The practice benefited from on-site community services where patients could be directly referred. These were provided by the Clinical Commissioning Group and not part of the practices working within the building. These services included health visitors, community nurses, wound dressing, speech and language therapy and a shared phlebotomy service. This enabled patients to access them easily after being referred by their GP.

District nurses were also situated in the same shared building. They had started to attend meetings recently to discuss the care and support needs of patients and they then updated patient records with action taken, to ensure the GPs were aware of the current position with their health needs.

One carer told us how the practice had helped identify the relevant agencies that they could work with and provide support to help their relative live independently. These included social services, occupational therapy and outreach rehabilitation. The practice worked with other the health care providers in the building a coordinated way.

A dedicated member of staff was responsible for sending referral letters to specialists so they were received in a timely fashion. To support patients to 'choose and book' their own specialist or hospital, telephone contact was

Good

Are services effective?

(for example, treatment is effective)

often made with them to provide advice and guidance. Urgent referrals were made on the same day whenever possible and routine referrals were usually completed within three to five working days.

Multi-disciplinary team meetings took place monthly with other health care professionals. These were attended by the GPs, the practice nurse, district nurses, midwives, a lead pharmacist for the Clinical Commissioning Group and palliative care nurses. A discussion took place about patients with complex needs or near the end of their lives and a register was in place to help monitor their condition. Patients were discussed on an individual basis with a joint approach, planned to provide the most appropriate care and treatment and to reduce the number of avoidable admissions to hospital.

These meetings were attended by GPs, social workers and district nurses and all patients on the register had a named GP. Minutes of these meetings were viewed which reflected that discussions were held about patient needs and care plan designed to provide the most appropriate care and treatment.

The practice received updates, letters and test results in a number of different formats, such as letters, emails and faxes. The clinical staff at the practice reviewed the information available to ensure changes in care and treatment were noted and then updated patient records.

Patients could receive test results by telephoning the practice. Where patients did not call and there was a need for them to attend the practice, they were contacted and advised to attend to speak with a GP.

Patients we spoke with told us that they had experienced continuity of care after seeing a specialist and that the GPs had been made aware of all relevant facts when they had a follow-up appointment. They also told us that any changes of medicines had been passed on correctly to the GP.

Information Sharing

We found that information was being shared between other health care providers and the practice in relation to their patients. Where hospital discharge letters had been received, these were dealt with on the same day, summarised then entered onto the patients' record. The GP was then notified.

The practice also liaised with external agencies to identify patients who had been involved in incidents where they might be at risk. These cases were noted on patient records and brought to the attention of one of the GPs.

Patients wishing to see a GP after the surgery had closed, used the 111 'out of hours' service. Information about any consultation was received by the practice by 8am the following morning and patient records updated. This ensured that GPs always had current information about a person's condition. Where a concern had been raised, the person updating the patient record brought it to the attention of one of the GPs through the electronic patient record system.

A 'choose and book' system was in use that enabled patients to select their preferred hospital and administration staff helped support patients to use this facility.

The practice used a computerised patient record system known as 'SystmOne' and staff made effective use of it. Consultations, test results and out patient outcomes were saved into the system so all staff could access the latest information about a patient to enable them to meet their needs.

Consent to care and treatment

A consent policy was available that described the different types of consent that were required. These included verbal, written and where consent could be given by a family member or a friend acting on a patient's behalf.

Staff spoken with were aware of the different types of consent required from patients attending the practice and the guidance from the Mental Capacity Act 2005. Where appropriate patients with learning difficulties had their mental capacity assessed to establish whether they were able to consent to care and treatment. This was then recorded in their patient record. Forms were available to record written consent when required.

Staff understood the guidance known as Gillick Competence. This is where a child aged 16 or under is able to consent to care and treatment without a parent or guardian being present. If a patient of such an age requested an appointment without their parent or guardian being present, they would be given one to see the GP. The GP would then assess whether the child fully understood the nature of the care and treatment required.

Good

Are services effective?

(for example, treatment is effective)

Nursing staff were aware of the need to take appropriate consent when a child attended the practice with an adult that may not have been their legal guardian. For appointments requiring a vaccination, if there was any doubt, the parent would be contacted prior to administering and appropriate consent obtained, followed up with written consent that was entered onto the patient's record.

Staff spoken with explained they were careful to ensure the patient only, received information about their care or treatment. Prior to giving out any information to a third party, the patient records were accessed to check whether consent had been provided by the patient. If not, this was discussed at a later stage with them and formal consent taken.

Health Promotion & Prevention

There was a pro-active approach at the practice to identify patients who might benefit from a health check appointment with one of the clinical staff. This included offering lifestyle advice, such as smoking cessation, to enable people to live healthier lives. These appointments were also used to identify carers by asking appropriate questions then offering them support.

The reception and waiting room area contained a range of information in leaflet and poster form to encourage people to live healthier lives, access support services and take part in immunisation programmes. There were leaflets available on smoking cessation, dietary advice and chlamydia screening.

New patients to the practice were supplied with an information pack, registration forms to complete and a questionnaire about their medical history. They were then booked in for an appointment with the nurse practitioner who initially assessed their medical needs and history. They were offered healthy living advice if required. Once assessed they were invited to book an appointment with one of the GPs if a health concern had been identified.

Healthcare checks took place for patients over the age of 75 and where concerns were identified the patient was then seen by one of the GPs. For the elderly and those patients with relevant medical conditions, flu vaccinations were promoted and posters were displayed advising them of their availability.

Patients were also able to book appointments with the practice nurse to receive consultations for the more minor illnesses and conditions. This helped the GPs focus on the more complex health needs of patients. However if a more serious issue was apparent, patients were referred to a GP.

The computerised patient record system was used to identify those patients who were eligible for national immunisation programmes or suffering from conditions that required regular review and monitoring. Patients had been contacted and invited to attend the practice when appropriate.

The practice had a register for those patients over 18 with a learning disability. They were monitored and provided with annual health checks and double appointment time was allocated for this purpose. The performance of the practice was above average in relation to this area.

The practice website contained useful information for patients to manage their conditions and live a healthier lifestyle. For patients with long term conditions this included links to other websites where more detailed advice could be accessed.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The reception desk was open plan and used by all three practices in the building using their own staff. Conversations could be overheard by patients waiting to be seen and the practice were aware of this issue and had arrangements in place to protect people's privacy.

Staff supported patients wishing to discuss something confidentially either by speaking with them away from the reception area or by taking them to a private room. Patients spoken with told us that staff respected their privacy at reception and during consultations.

They also told us that the reception staff were friendly and helpful and if a confidential matter needed to be discussed they were able to speak to them in private. During the inspection we observed staff at reception speaking with patients who had attended the practice. They were treated courteously and with respect.

The results of the patient survey in January 2014 showed high levels of patient satisfaction with the way they were treated at the practice with very few negative comments. The comment cards we viewed also reflected the same high levels of satisfaction.

Patients we spoke with on the day of our inspection were generally complimentary about the way they were treated at the practice. They told us that explanations were clear and that clinical staff gave them time to discuss their issues.

Staff told us that when providing test results over the telephone or at reception, they would confirm a patients identity beforehand. If leaving a message on a person's telephone they would not leave any personal details but request that the patient call the practice. Staff were aware of privacy and confidentiality issues and managed people's personal data effectively.

Consultation and treatment room doors were closed during examinations and could be locked if necessary. We could not hear conversations taking place inside them. Privacy curtains were available in each consultation room for physical and intimate examinations. Chaperones were available for patients to use if required and signs were in the waiting room bringing this service to their attention. If available, a patient could see a GP of their choice or request either a male or female GP.

Care planning and involvement in decisions about care and treatment

Patients we spoke with were satisfied with the explanations they were given by clinical staff about their care and treatment and felt they were involved in the planning of it. They told us they were given time to discuss their concerns and did not feel rushed. We spoke with a carer on the day of our inspection who told us that they had been involved in a discussion about the options for their relative and had been helped to understand and decide upon, the options available to them.

The results of the practice survey in January 2014 reflected that patients were very satisfied with the consultations and the information they received from the GPs and nurse. The CQC comment cards also confirmed this opinion.

Staff were aware of the potential need to interpret for patients whose first language was not English. If required they would access support from colleagues who spoke the same language or through the use of interpreting services.

Patient/carer support to cope emotionally with care and treatment

Staff at the practice offered emotional and practical support for those who had recently suffered bereavement. They were referred to external organisations that provided specialist services as well as offering compassion and a time to talk if a relative wished to do so. Appointments with the GP were offered if a need was identified. Patient records were updated with details of the bereavement so that when a patient attended the practice staff were able to respond appropriately.

Literature in the form of leaflets and posters were displayed in the waiting room area signposting a number of support groups and organisations that could be accessed for patients, relatives and carers. These included information about support for those suffering from long term conditions such as cancer and diabetes and advice for carers in relation to equipment and benefit payments. When a new patient registered at the practice they were asked if they were a carer and offered appropriate support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice understood the needs of the patients using the service and planned their services to meet those needs.

The practice told us that patients could get an appointment with the GP of their choice and they received continuity of care. The practice had both male and female GPs and this choice was also accommodated wherever possible. Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Chaperones were also available for patients who wished to make use of them when undergoing examinations.

Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate, usually after the morning and afternoon surgeries. Information about this service was also available on the practice website.

Appointments with the nurse were readily available and patients were seen on time and rarely had to wait. The practice had found it unnecessary to run specialist clinics for the patients who used the practice. The nurse was able to see all patients on an appointment basis. This included meeting the needs of mothers and babies, patients with long term conditions and providing services such as seasonal flu inoculations, travel vaccinations, cervical screening and child immunisations.

A service was provided for patients with poor mental health. A trained nurse mental health counsellor was employed by the practice and worked one day each week. This ensured that people suffering with mental health issues could obtain regular advice and support. Comment cards we left for patients to complete prior to the inspection, reflected that this service was effective and had changed people's lives for the better.

Some members of the clinical and non-clinical staff had attended courses to learn about patients with learning disabilities. This helped them understand the needs of this vulnerable group of patients. Double appointment times were allocated to patients with learning difficulties requiring annual reviews of their health. A register of patients was being maintained and patients contacted pro-actively if they were due for a health review. At this health check carers were spoken with and support offered to them. This included where they could obtain financial assistance as well as advice on how to access support groups.

The practice patient list included elderly residents of a local care home. An effective system was in place for the management of prescriptions for the patients living there and for visiting them for consultations or health checks. Other patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours but patients we spoke with told us that they were often ready for collection earlier.

The practice had tried unsuccessfully to form a Patient Participation Group, but other systems were in place to obtain patient, staff and other feedback where improvements were identified and changes made to improve services. As a result of comments made in the patient survey, additional receptionists were used to deal with requests for appointments at peak times.

Tackling inequity and promoting equality

The practice was aware of the variety of different languages spoken by their patients. Generally patients came with a relative or a friend to interpret for them if English was not their first language. The practice had not yet needed to use an interpreting service but would do if the need arose to provide explanations about diagnosis, care and treatment options.

The staff at the practice were able to speak Asian languages and dialects and this supported patients to understand their consultations, care and treatment explanations. Staff displayed knowledge about the different needs of patients in relation to their cultures and beliefs.

Members of the travelling community were encouraged to register at the practice and a temporary residents registration pack was available for them to complete, followed by a health care consultation. The practice were aware that their patient list included refugees and they were offered support if required.

The premises and services available met the needs of people with disabilities. There was plenty of space

Good

Are services responsive to people's needs?

(for example, to feedback?)

available for wheelchair users, all consultation rooms were accessible and suitable disabled toilet facilities were available. A lift was available to access other floors of the premises.

Access to the service

Appointments with GPs were available weekdays each morning and afternoon except on Wednesdays when the practice was closed from 1pm. A late evening surgery ran on Thursdays until 8pm. The practice did not open at weekends. Telephone lines were open from 8.30am each day to book appointments.

An 'out of hours' service was available when the practice was closed or by the emergency 111 service and this was made clear in the reception area and on the practice website. An answerphone service also explained how to access this facility.

The late evening surgery provided a service for the working age population. Although one patient we spoke with was aware of this, they had still found it problematic getting an appointment, but had recently noticed an improvement.

Appointments with the GPs or nurse were generally available on the same day. Preference was given to urgent matters or where young children were concerned. Where there was a need, additional appointments were made available beyond the morning or afternoon surgeries. If this was not possible arrangements were made for one of the GPs to phone the patient back to undertake a telephone consultation, provide advice or arrange a home visit. Where patients were suffering from minor illnesses, the practice nurse was qualified to see them and provide a consultation and treatment.

Patients we spoke with told us that they were generally satisfied with the appointment system but opinions differed. Some patients had experienced being able to obtain a same day appointment with a GP but others had found it more difficult. Some people had found that when the matter was urgent they could be fitted in on the day. Comment cards that had been completed prior to our inspection and the 2014 patient survey, reflected that patients were satisfied with the appointment system.

The practice had a system in place to monitor those patients that did not attend for their appointment and to provide them with feedback. The practice website also encouraged patients to phone in and cancel if they had to, so their appointment could be offered to someone else. The practice made use of a mobile text service to remind patients of their appointment time or to notify them that a review of their condition was due. This helped reduce the number of patients who did not attend for their appointments.

The practice was situated in a three storey health centre shared with two other GP practices. The waiting room and reception area were spacious and could accommodate wheelchair and mobility buggy users. Parking for people with disabilities was available in an adjacent car park. All parts of the building were accessible for patients who were disabled and a lift was provided. There were sufficient numbers of chairs available for patients waiting to see their clinician. There were also toilet facilities for disabled people.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and reviewed in September 2014. There was a designated person responsible for handling all complaints at the practice and a lead who dealt with the final outcome of the complaint and made the appropriate decisions.

The partners at the practice had recognised that as a family run practice, they needed a level of independence to handle any complaints that they received. This was necessary to avoid a conflict of interest where a relative could be in the position of investigating a complaint against another family member. They therefore allocated the role to a member of staff who was not related to the partners.

The practice leaflet contained details of how to make a complaint and this was available in the reception area for patients to view. Complaint forms were also available for patients to complete. The practice website also contained information for people wishing to make a complaint.

The member of staff responsible for handling complaints, told us that staff were encouraged to notify them as soon as a complaint was made to provide an opportunity for meeting the patient as soon as possible in private, in order to deal with the matter. Patients were asked to put the more formal complaints into writing but if a verbal complaint was made it would be dealt with in line with their policy.

Good

Are services responsive to people's needs?

(for example, to feedback?)

If the complaint was of a minor nature it would not necessarily be recorded but dealt with so that patients could have their grievance heard and acted upon.

Staff spoken with told us that the monitoring and reviewing of complaints led to learning opportunities which were cascaded to them at monthly staff meetings. An annual 'look back' took place each year to review the complaints that had been made. Staff were aware of the procedures to follow if a complaint was made.

Patients spoken with on the day of the inspection would bring any complaint to the attention of reception staff or the practice manager. All those we spoke with had not ever felt the need to complain.

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

We found that the practice was lacking in strategic direction and the vision for the future was unclear. The practice had a statement of purpose but some staff were not aware of its content. Staff had not been asked to participate in the vision and strategy for the future and to contribute to its development and were not aware of the direction that the practice was heading or how they could influence progress.

On speaking with the GPs, it was evident that the future structure of the practice was unclear. Although the practice was providing satisfactory care and treatment, there was a lack of short, medium and long term vision and strategy and therefore progress could not be monitored against the objectives. The practice could benefit from a vision and strategy to work towards.

Governance Arrangements

Regular clinical and non-clinical team meetings were held where performance was discussed and locum GPs were invited to attend if they were at the practice on that particular day. All meetings were minuted. We looked at four sets of minutes and all had been completed to a satisfactory standard and covered all relevant issues.

The practice had a range of policies and procedures to maintain standards and to provide the most appropriate care and treatment. These included consent, infection control, medicines management, patient confidentiality and safeguarding. We viewed a number of policies and procedures in use at the practice and they had all been the subject of regular review and circulation to staff.

Staff spoken with were clear about their roles and responsibilities and who was accountable for each area of the practice so they were able to direct queries or concerns to the most appropriate person. Leads had been identified for key area such as infection control, complaints handling and safeguarding.

The services provided by the practice were monitored regularly using the Quality Outcomes Framework. This ensured that the practice was on target to deliver effective health care for patients.

The practice had undertaken a number of clinical audits including infection control, prescribing patterns, referral rates to hospitals, unplanned hospital admissions and significant event reviews. Although audits were taking place there was an absence of an audit timetable or cycle to reflect that audits were being undertaken more than once to ensure that any improvement areas had been maintained. The practice have agreed to review their audit processes.

Leadership, openness and transparency

All staff we spoke with told us that they were satisfied with the leadership at the practice. They told us they were supported and advice was readily available. They told us that training opportunities were made available to them and they were encouraged to self-develop.

The partners at the practice met regularly to discuss both clinical and leadership issues. Policies were reviewed and brought up to date if necessary. The policies we looked at reflected that there was a review process in place that was effective.

All staff we spoke with told us that they were encouraged and supported to raise issues to improve performance at the practice. They all felt confident they would be listened to and action taken if appropriate. A monthly staff meeting took place and staff were able to add items to the agenda that they wished to discuss. They felt able to raise concerns both in meetings or in private if they wished and where matters were confidential this was respected.

The practice manager also worked on the reception desk to support the staff when there were shortages. We were told that this helped them have an insight into the problems faced in this role, to understand the demands and identify where improvements could be made, from a leadership perspective.

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

The practice last held a patient survey in January 2014. Questionnaires were completed by patients who were asked to comment on the services provided at the practice. The practice website also gave patients an opportunity to provide feedback through an on-line survey. The analysis of

Are services well-led?

Good

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

the survey results reflected high levels of patient satisfaction across all areas. These included consultations, appointment availability, waiting time, explanations and access to their choice of GP.

Where improvement areas had been identified, an action plan was in place to address them with timescales, and records held reflected the date of achievement of these improvements. The practice had responded to patient comments and some examples of this were providing more staff to answer telephone calls at peak times, patients being updated about any delay whilst waiting to see a GP and telephone consultations being made available at the end of surgeries.

The practice also sought direct feedback about the performance of the GPs using an externally purchased appraisal toolkit. Patients of different ages and population groups were invited to complete a questionnaire about their GP. Other health care professionals, both colleagues and external partners, were also asked to complete a detailed questionnaire from their own perspective. This was followed by an analysis of the results.

The GPs were then presented with the results of the analysis to see where improvements might be made by them. They then produced a short document reflecting on the comments that had been made and where they might improve.

Staff we spoke with told us that quarterly staff meetings took place and their views were sought in order to improve the services provided. They told us that there was a culture of openness at the practice and staff were encouraged to speak out and relevant ideas adopted. We viewed the minutes of some of these meetings and found that staff were encouraged to provide feedback about where the practice could improve.

The practice had tried unsuccessfully to form a Patient Participation Group (PPG). This is a group of volunteer patients who meet regularly and discuss ideas as to how the practice could be improved. They have found it difficult to obtain sufficient volunteers to make it viable despite promoting it at the practice and on their website.

Management lead through learning & improvement

The practice used several methods to learn and improve the services they provided at the practice. Where learning had been identified this was discussed at staff meetings, but if it was an issue that required more urgent attention, a system was in place for staff to receive a memorandum which they were required to sign. These were monitored to ensure all staff had read them, then retained for audit purposes.

The various methods used to identify areas for improvement included significant event analysis, complaints monitoring, patient surveys and feedback, staff appraisals and feedback from other healthcare professionals.

Significant events were recorded and analysed, improvement areas identified and action taken. Complaints were handled by a dedicated member of staff and learning was apparent. An annual 'look back' provided further opportunities to sustain improvements. The appraisal process was used to identify learning and improvement opportunities. Staff were requested to identify training that would benefit their role and improve outcomes for patients. Patient surveys identified not only where services could be improved but also the performance of the GPs across a range of skill areas.

In all cases, where improvements had been identified there was a system in place to cascade them to staff and to ensure they were followed through to completion.

Quarterly meetings also took place with other GP practices in the local area to discuss issues and identify joint learning. This learning was cascaded to staff through clinical and non-clinical staff meetings.