Dr AJM Murdoch's Practice

Quality Report

The Cornerstone Practice
Shadsworth Surgery
Shadsworth Road
Blackburn
Lancashire
BB1 2HR
Tel: 01254 665664
Website: www.cornerstonepractice.com

Date of inspection visit: 19 November 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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr AJM Murdoch's Practice.

We carried out a comprehensive inspection on 19 November 2014. We spoke with patients, members of the patient participation group and staff, including the management team.

The practice was rated as good overall.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- The practice was proactive in using methods to improve patient outcomes. Best practice guidelines were referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation.
- Feedback from patients was consistently positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to provide kind and compassionate care. They worked hard to overcome obstacles to achieving this.
- The practice reviewed the needs of their local population and had initiated positive service improvements for patients that were over and above their contractual obligations. They implemented suggestions for improvements as a consequence of feedback from the patient participation group.
- The practice had a clear vision which had quality and safety as top priorities. High standards were promoted and owned by all practice staff with evidence of team working across all roles. There was a strong governance structure in place. The leadership culture was open and transparent. The practice had a clear understanding and commitment to the needs of staff. We found high levels of staff satisfaction.
- The quantity and quality of audits completed by the practice over the last year. The clinical audits we reviewed were very comprehensive and to a high standard. We saw that a number of non-clinical audits had also been completed.

Summary of findings

We saw several areas of outstanding practice including:

- The practice adopted a wide definition of hard to reach groups and had devised and implemented a strategy in relation to each. Identified groups included people from lower socio economic groups, homeless people, lone pensioners and teenagers.

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lesson were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance is referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify appraisals and personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice highly for all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found positive examples to demonstrate how patients' choices and preferences were valued and acted on.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group. The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients reported good access to the practice 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 an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated good for providing well-led services. The practice had a clear vision which had quality and safety as top priorities. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current best models of practice. We found there were high levels of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had an active patient participation group.

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 the practice had good outcomes for conditions commonly found amongst 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 care. The practice was responsive to the needs of older people, including offering home visits.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long term conditions. When patients needed longer appointments and home visits they were available. Emergency processes were in place for patients in this group that had a sudden deterioration in health. The practice was participating in an enhanced integrated care service pilot to identify those at risk of unplanned admission or A&E attendance. Patients at moderate risk were referred to a self-care facilitator for support and management. All patients had structured annual reviews to check their health and medication needs were being met. Longer appointments were available and systems were in place to enable patients with multiple conditions to have reviews that encompassed all matters on the same occasion, reducing the need for additional visits. For those people with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Educational events about long term conditions were run by the practice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify and follow up those children who lived in disadvantaged circumstances and who were at risk. For example, children and young people with a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisation and effective systems were in place to follow up on any non-attendance for appointments.

The practice was taking part in enhanced services to catch up on mumps, measles and rubella vaccination for young people and to promote testing for chlamydia. They also participated in a local initiative making free condoms available to all. Children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside school hours and

Summary of findings

the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. The practice had a noticeboard dedicated to local services for young people.

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 this group had been identified and the practice had adjusted the services it offered to ensure they were accessible and flexible. The practice offered on-line services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice had adopted a wide definition of hard to reach groups and devised a strategy in relation to each. These groups accounted for 90% of the patient population.

The practice had a good understanding of the demographics of the area it served and was responsive to meeting patients' needs. There were high levels of engagement with other healthcare services and support organisations in the area to assist them to provide timely and effective support as required.

They maintained a register of patients living in vulnerable circumstances including homeless people, those with learning disabilities and patients with visual loss. Longer appointments were offered to patients with learning disabilities. The practice participated in enhanced services targeting drugs misuse.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Those with poor mental health received annual physical health checks. They were taking part in three enhanced services encouraging earlier diagnosis and treatment of those experiencing poor mental health. These included an opportunity to review the

Summary of findings

needs of any carer. The practice regularly worked with multi-disciplinary teams in the case management of these patients. They had strong links with a number of local support organisations and referred patients to a wide range of different services.

Summary of findings

What people who use the service say

We received 17 completed CQC comment cards and spoke with five patients visiting the surgery on the day of inspection. We received feedback from male and female patients across a broad age range. All patients we spoke with had been registered at the practice for many years. One of the patients we spoke with made a point of telling us that their journey to the practice involved taking two buses but they thought so highly of it they would not consider moving elsewhere.

Patients spoke positively about the practice, and the care and treatment they received. Their descriptions of staff included excellent, helpful, kind and friendly. One person commented that staff at the practice always went the extra mile. Patients felt they were treated with compassion, dignity and respect. They told us staff listened to them and took time to discuss and explain treatments and options. Patients felt involved in the planning of their care and treatment.

Patients who commented on the ease with which they could get an appointment were generally satisfied. They said they were seen in a timely manner when they arrived for an appointment and did not feel rushed during their consultation. They told us that appointments could be easily arranged by telephone, online or in person. One person said that on occasion there could be problems getting through to the practice by telephone or delay in being seen at the reception desk.

Several patients commented on the environment. The majority told us it was welcoming, comfortable, clean, tidy and warm.

The most up to date results available from the national GP patient survey showed that 93% of those who responded said their overall experience of the surgery was good. 86% rated their overall experience of making an appointment as good. 94% said reception staff were helpful. 89% said that GPs were good at giving them enough time and listening whilst 84% said the same of nurses. 80% of respondents said the GPs were good at treating them with care and concern, and 82% said the same of nurses.

Outstanding practice

- The practice adopted a wide definition of hard to reach groups and had devised and implemented a strategy in relation to each. Identified groups included people from lower socio economic groups, homeless people, lone pensioners and teenagers.

Dr AJM Murdoch's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP, a specialist advisor practice nurse and an expert by experience.

Background to Dr AJM Murdoch's Practice

The Cornerstone Practice is a partnership with a Christian foundation that operates three surgeries, each maintains a separate patient list. The main one is Dr AJM Murdoch's Practice which is known locally as Shadsworth Surgery. The practice is situated in the Shadsworth area of Blackburn. Dr AJM Murdoch's Practice is the largest one in the partnership with a registered patient list of 8250. It was opened by Dr Alastair Murdoch in 1988 with the vision to provide excellent primary health care to the needy residents of the Shadsworth estate, which has many single parent families and a high level of deprivation and unemployment.

Seven GPs and seven members of nursing staff work at the practice. The nursing team includes an advanced nurse practitioner and a lead nurse. The clinical team includes both male and female GPs and nurses. The practice is a training practice for doctors who wish to become GPs. There was one Registrar attached to the practice at the time of inspection. Non-clinical staff include a site manager, reception, administrative and secretarial teams.

The practice opening hours are 8.30am to 6.30pm Monday to Friday with extended opening hours on Mondays until 8.15pm. All surgeries are by appointment. Home visits are available for patients who were housebound or too ill to attend the surgery. When the practice is closed the care and treatment needs of patients are met by an out of hour's service, East Lancashire Medical Services based at the local NHS hospital.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest level of deprivation and level ten the lowest. The practice has a significantly lower percentage of patients within the age group band 50 to 85 years than the national average. It also has a significantly higher percentage of patients within the age group band 0 to 35 years. This is particularly so for children aged up to 10 years.

The practice operated under a locally agreed contract to provide personal medical services (PMS).

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- 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)

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. We spoke with the chair of the Patient Participation Group by telephone. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 19 November 2014. During our visit we spoke with three GPs, members of the nursing team, the practice manager, site manager, facilities manager, quality and community development manager, reception and administration staff. We observed how staff communicated with patients. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed documentation and clinical indicators, such as the child immunisation, cancer detection and cervical screening rates that showed the practice had a track record of safety and performance.

The site manager was aware of their responsibilities to notify the Care Quality Commission about certain events, such as occurrences that would seriously reduce the practice's ability to provide care.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. The records kept of significant events that had occurred were made available to us. These were comprehensively documented and analysed. Lessons learned were extracted and shared with staff through team meetings. We saw that changes in practice had been applied, for example, to the practice procedure for scanning documents. This helped to ensure the practice maintained a regime of continuous improvement.

National patient safety and medicines alerts were reviewed by the practice manager on receipt and shared with staff appropriately to ensure they were acted upon.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received safeguarding training to an appropriate level. All GPs had been trained to level three, nursing staff to level two, reception and administrative staff to level one. Staff knew how to recognise the signs of abuse and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns, and how to contact relevant agencies in and out of hours. Contact details were readily accessible.

One GP took responsibility as practice lead in relation to safeguarding. The lead met with the health visitor appointed to the practice every two weeks to address any concerns. Staff we spoke with knew who they should speak with in the practice if they had a safeguarding concern. The practice had comprehensive safeguarding policies and procedures for children and vulnerable adults. These were up to date and readily accessible to staff.

There was a system to highlight vulnerable patients on the practice's electronic records and include information to make staff aware of any relevant issues when patients attended for appointments, for example, children subject to child protection plans.

The practice had a chaperone policy in place. Notices were displayed in the waiting area advising patients that they could request a chaperone during their consultation if they wished. It was practice policy that only members of clinical staff would act as chaperones when a request was made.

Patient's individual records were managed in a way that helped ensure safety. Records were kept on an electronic system which collated all communications about the patient, including scanned copies of communication from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures and this was being followed by practice staff.

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. There were stock controls systems in place to ensure there were adequate supplies of medicines in treatment rooms and in GPs bags at all times.

Each week the practice received a visit from a member of the CCG medicines management team who audited medicine issued in line with current clinical guidance. Recent audits had included use of emollients, eye drops, diabetes medicines, high cost drugs, vitamins and laxatives. We saw that action was taken in response to review of prescribing data. The practice had been completed two audits in relation to diclofenac prescribing as a response to new guidelines issued by the Medicines

and Healthcare products Regulatory Agency (MHRA). We saw that the audit had been repeated. A second audit In May 2014 showed a marked performance improvement when compared to the results of the first audit cycle in 2013.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to do so.

There was a protocol for repeat prescribing which was in line with national guidance and followed in practice. The protocol complied with the legal framework and covered all required areas, such as how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by the issuing GP before they were given to a patient. Only GPs or nurse prescribers were able to amend patient medication records. Prescription pads were stored securely in the practice, though taken out by some GPs in unlocked bags for home visits. A system was in place whereby uncollected prescriptions were periodically reviewed. Older uncollected prescriptions were recoded and destroyed where subsequent ones had been issued. Staff told us that if a patient had an uncollected prescription and the records showed that no further prescription had been issued it was brought to the attention of a GP.

A system was in place for the management of high risk medicines. This included regular monitoring of patients in line with national guidance. The practice tried hard to ensure continuity for prescriptions of controlled drugs, for example, only two of the GPs dealt with prescriptions for methadone.

Cleanliness and infection control

A member of the nursing staff led the practice in relation to clinical aspects of infection prevention and control. The facilities manager led in relation to non-clinical aspects. All staff received induction training about infection control and annual updates thereafter. We saw the next training session for all staff was scheduled for January 2015.

We observed the premises to be clean and tidy. Arrangements were in place with an external contractor for the cleaning of the practice. We saw there were comprehensive schedules in place and cleaning records were kept. Patients who commented on the environment told us they had no concerns about cleanliness or infection control at the practice. One patient told us had found the baby change facility to be dirty when they had gone to use it. The cleaning company carried out regular quality assurance audits of the premises. The results were presented to the facilities manager for consideration and verification before they were signed off.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There were protocols for procedures such as hand washing, dealing with a needle-stick injury and with spillage of blood or bodily fluids. Records showed that when a member of staff had recently received a needle-stick injury the protocol had been followed.

The role of the clinical staff included maintaining infection control measures in treatment rooms throughout the practice day and ensuring there were adequate supplies of stock. We noted that treatment rooms appeared clean and tidy and cleaning schedules were in place.

Clinical staff also responded to any spillages of blood or bodily fluid that might occur. We saw the practice followed procedures to check the immunisation status of clinical staff. They were required to provide hard copy evidence of immunisation against Hepatitis B, measles and chicken pox. These measures did not apply to non-clinical staff and this had been risk assessed. Non-clinical staff were not involved in this activity. There was clear instruction to reception staff on the procedure to be followed in accepting specimens from patients at reception. Reception staff were advised not to handle samples and supplied with gloves to wear whilst holding a bag open for the patient to place their sample into.

Hand washing instructions were displayed in staff and patient toilets. Hand washing sinks with soap, gel and hand towel dispensers were available in treatment rooms. There were signs in reception advising patients hand gel was available on request.

The practice had systems in place for segregation of clinical and non-clinical waste. There were sharps bins in each treatment room which were located so they were not

readily accessible to patients. An external contractor attended the practice on a weekly basis to collect clinical waste and remove it off site for safe disposal. In the patient toilets the lighting was blue, a measure that can be taken to deter drug users from injecting drugs on the premises as the lighting hampers ability to locate a vein.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We found evidence to show the practice carried out regular checks in line with their policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Minutes of management meetings we viewed showed that sufficiency of equipment was kept under review. We saw maintenance logs and other records evidencing that equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last test date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example, ear syringes, thermometers and the defibrillator.

Staffing and recruitment

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

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. Generally staff worked at one particular surgery within the Cornerstone Practice. There was scope for the surgeries to assist each other if there was a business need which offered increased flexibility. For example, for a period one of the surgeries had assumed additional responsibility in relation to scanning incoming post to assist colleagues.

The practice had a stable staffing team with little turnover. Staff told us there were usually enough staff to maintain the smooth running of the practice and always enough staff on duty to ensure patients were kept safe.

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. These included regular checks of the building, the environment, medicines management, staffing and dealing with emergencies and equipment. There was a health and safety policy in place. Just prior to our visit the practice had completed their annual health and safety audit. The audit was comprehensive and included matters such as the control of substances hazardous to health, moving and handling, first aid and use of display screen equipment. Health and safety information was displayed on a noticeboard behind reception for staff to see and the facilities manager was the nominated health and safety representative for the site.

Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the building and equipment. Fire alarms and extinguishers were placed throughout the building. The fire exits were well signposted and free from hazards to prevent escape in an emergency.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of the equipment and records showed it was checked regularly.

Emergency medicines were available in a secure area of the practice and staff knew of their location. Processes were in place to check the emergency medicines were within their expiry date and suitable for use. The emergency medicines we checked were clearly labelled, in date and fit for use.

A disaster recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the

Good

Are services safe?

practice. Risks identified included power failure, access to the building, and loss of the telephone or computer system. All staff had access to the plan. Key contact names and telephone numbers were recorded in it.

Fire alarm systems were tested weekly and a test evacuation drills carried out every six months. The fire alarm systems had been fully serviced in October 2014.

All staff received fire safety training as part of their induction and refresher training annually thereafter. The facilities manager had completed a fire safety management course to enable them to fulfil their additional responsibilities in this area. We saw evidence that the facilities manager last completed a full risk assessment of premises on 5 November 2014 and the results had confirmed there were no additional actions required.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice had a scheduled programme of clinical and protocol meetings providing a regular forum for new guidelines to be shared and discussed. We found from our discussions with GPs and nurses that, in line with NICE guidelines, staff completed thorough assessments of patients' needs and that these were reviewed as appropriate.

GPs had special clinical areas of interest in which they lead the practice, for example, diabetes, chronic obstructive pulmonary disease (COPD), asthma, children's and women's health. Members of the nursing team also held additional qualification in particular clinical areas and ran clinics to monitor chronic conditions and support patients in management of them. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, and past symptoms diagnoses. These codes improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. Quarterly data quality audits were carried out by the CCG Data Quality Team to ensure up to date data was available on the electronic system.

Referrals to secondary care were made in line with national standards. There were effective systems in place to ensure that all incoming post to the practice was coded, attached to the relevant patient's records and brought to the attention of the GP in a timely manner.

Management, monitoring and improving outcomes for people

Patients' comments demonstrated that they were extremely satisfied with the care and treatment received from GPs and nurses at the practice. Staff said they could openly raise and share concerns about clinical performance.

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

The practice showed us examples of clinical audits completed within the last year. These included diclofenac prescribing, COPD diagnosis procedures, and bowel cancer screening. The practice received weekly visits from a member of the CCG medicines management team. They had an on-going programme of auditing medicines issued in line with current clinical guidance. We saw that this had included sip feeds, emollients, diabetes medicines, vitamins and high cost drugs. We saw a number of non-clinical audits had also been completed. Examples included audit of data quality and access to GP appointments.

The audits we reviewed were very comprehensive and to a high standard. Results were analysed and any actions identified implemented. For example, as a result of auditing capacity and demand for GP appointments the practice had increased the number of book on the day appointments available. Learning was shared appropriately across the staff team.

Staff told us medicines management and safety alerts were shared with them and any actions required were implemented and fully recorded in a short timescale.

The practice used the information they collected for the Quality Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF data was subject to on-going monitoring to ensure the needs of patients were identified and met in a timely manner. For example, to ensure that those with long term conditions, learning disabilities or mental health issues attended for regular review. The practice had systems to recall patients when their review was due and proactively follow up on any non-attendance. The data was also monitored to ensure that when patients were due for vaccinations, such as shingles, flu and child immunisations, they received them.

The practice was taking part in a local enhanced integrated service pilot coordinated by the CCG with a view to reducing emergency hospital admissions. Using a risk

Good

Are services effective?

(for example, treatment is effective)

stratification tool patients at high and moderate risk were identified and then managed and supported by a community nurse or self-care facilitator. They were also taking part in three enhanced services encouraging earlier diagnosis and treatment of those experiencing poor mental health. These included an opportunity to review the needs of any carer.

Regular clinical meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of patients.

Effective staffing

All the patients we spoke with were complimentary about the staff. We observed staff who appeared competent, comfortable and knowledgeable about the role they undertook.

The provider had a formal induction process for any new staff joining the team. New members of staff completed an induction programme tailored to meet the requirements of their role.

All staff maintained a range of mandatory training, including fire safety, basic life support and safeguarding of adults and children. The practice also provided access to additional role specific training for clinical and non-clinical staff. Each month there was some protected learning time to enable staff to pursue their further development. There were opportunities to attend internal training sessions, multi-disciplinary team and CCG events.

Historically the practice had maintained records of staff training by retaining attendance sheets. We saw that they were in the process of compiling an overarching training matrix.

All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation set. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs identified. Staff interviews confirmed the practice was proactive in developing staff by providing training and funding for relevant courses. For example, one of the practice nurses was working towards qualification as an advanced nurse practitioner. Advanced nurse practitioners are able to undertake additional treatments than practice nurses and see a broader range of patients.

The practice was a training practice for doctors who were in training to become qualified GPs. At the time of our inspection there was one doctor attached to the practice. They were offered extended appointments to see patients and had access to the senior GP throughout the day for support.

The practice also participated in an apprenticeship scheme offering apprentices in medical administration work training experience to prepare them for work. The first apprentice to join the practice had completed their training and been offered permanent employment. At the time of our inspection a second apprentice was in training with the team.

The practice had adopted a staffing model to ensure they had an appropriate number of staff and mix of skills to meet patients' needs. Staffing levels were kept under review. We saw that audits completed by the practice had included one in June 2014 in relation to the staffing level of healthcare assistants.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for patients.

The practice proactively engaged with other services to extend and improve the care and treatment options available to meet the needs of their patient population. They offered a number of enhanced services and participated in local pilot schemes to achieve this. Staff told us the practice was recognised for its willingness to engage and work with like-minded colleagues for the benefit of their patients. From speaking with staff it was clear this was something they took pride in.

GPs regularly attended multi-disciplinary meetings to identify patients for referral to the various projects in which they were involved and discuss progress. Mental health team counsellors, midwives, cognitive therapists and self-care advisors were amongst those who were associated with the practice and offered consultations on site. As part of an enhanced service the practice provided

Good

Are services effective?

(for example, treatment is effective)

substance abuse case management for their patients and those from other practices. Staff from the substance misuse team regularly attended the premises and saw patients on site.

In appropriate cases patients were also referred to services such as those dedicated to supporting adult survivors of sexual abuse, suicide bereavement groups, Christians Against Poverty, Asylum and Refugee Community (ARC), women experiencing domestic abuse (WISH) and the National Society for Prevention of Cruelty to Children (NSPCC).

The practice maintained a register of patient receiving palliative care and regular multi-disciplinary meetings were held to discuss their needs. There were good systems in place for information sharing and integrated care for those patients at the end of their lives.

Information sharing

The practice had a website with information for patients including signposting, services available and latest news. They also produced a quarterly newsletter, the Cornerstone Courier. We saw this included information about the practice and also forthcoming community events such as meetings of a local walking group.

GPs met regularly with practice nurses and administration staff at Dr AJM Murdoch's Practice and at the other surgeries within the Cornerstone Practice. Information about risks and significant events was shared openly and honestly. One GP attended CCG meetings and shared information from these with the staff. This kept staff up to date with current information around local enhanced services and requirements in the community.

The practice used electronic systems to communicate with other providers. For example, they were used to communicate with the out of hour's provider, to make referrals and received results from hospitals such as for blood tests and X-rays.

The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is provided to healthcare staff treating patients in an emergency or out of hour's situation which enables them to have faster access to key clinical information.

We saw the practice had IT systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. The software enabled scanned paper communications, such as letters from hospitals, to be saved in the patient's records for future reference.

GPs were able to access the electronic patient record system on a heavily encrypted iPad whilst on home visits.

Consent to care and treatment

The practice had a comprehensive policy on consent and decision making for patients who attended the practice. The policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate. A number of templates had been produced for completion in circumstances where written consent from the patient was required, for example, for minor surgery, ear syringing and travel vaccination. We were told that where patients gave verbal consent to care and treatment it was recorded in their notes.

Patients with learning disabilities and dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The GPs and nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

Health promotion and prevention

Each new patient registering with the practice was offered a health check with a member of the nursing team. This included discussions about their environment, family life, mental health, physical wellbeing as well as checks on blood pressure, smoking, diet, alcohol and drug dependency. Any health concerns highlighted were promptly referred to a GP and followed up. At the point of registration patients were also asked if they had, or were, a carer. The practice maintained a carer register and promoted the services of a carer's support group.

In one corner of the waiting area there was a surgery pod to encourage patients to self-check their blood pressure and weight. Readings from the blood pressure monitor were automatically captured and fed directly into the patient's records. If a reading was particularly high it raised an alert with reception staff who would then refer the patient to see a clinician.

Good

Are services effective?

(for example, treatment is effective)

The practice website, information booklet and surgery waiting areas provided information on a range of services and health promotion literature was readily available.

The practice proactively promoted self-care where possible and encouraged people to take ownership and responsibility for their health. One of the noticeboards in the waiting area was dedicated to self-care and signposted patients to self-help books available in the local library on a range of issues such as over eating.

There were a number of other noticeboards dedicated to particular subjects, for example, community news. We were told that on a rota basis the practice produced a young people's board which included advice on young people's services including pregnancy advice. The practice took part in the Blackburn and Darwen Wrapped scheme which made free condoms available to all.

Each quarter the practice produced a newsletter. Recent editions included information about a local walking group and signposting to stop smoking advisors. Also featured were details of information evenings held by the practice on topics such as dementia and diabetes. The practice specifically sent invitations to attend information evenings to patients for whom these issues were particularly relevant.

The practice was taking part in a local enhanced integrated services pilot seeking to reduce health care utilisation and improve the quality of life for people with long term conditions. Under the scheme the practice actively worked to identify patients meeting certain criteria for referral to the Achieving Self Care service. Patients at moderate risk were invited to meet self-care facilitators at the surgery who carried out holistic assessments and developed a tailored plan of action the patient could take to improve their health using community resources.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patient feedback was very complimentary about the practice and the care and treatment they received. Patients told us staff were kind, friendly and helpful. They told us they were well looked after and staff were genuinely concerned and attentive to their needs. One person commented that staff at the practice always went the extra mile.

Patients told us they were treated with dignity and respect. All consultations and treatments were carried out in the privacy of a consulting / treatment room. Privacy curtains were provided in the rooms so patients' dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy. We observed that reception staff were careful to follow the policy when speaking with patients in order that confidential information was kept private. Staff handling incoming calls to the practice were situated away from the reception desk and shielded by partitions which helped to keep patient information private. There was an area away from the main reception desk where patients could speak with reception staff in private if they wished.

The practice had a breastfeeding policy and notices in reception explained that private facilities were available to mothers wishing to do so. Each day one of the treatment rooms was kept free for this purpose.

In the reception area there was a surgery pod which patients could use to self-check their blood pressure reading and weight. The pod was located in a corner of the waiting area enabling patients wishing to use it to do so privately.

Staff were committed to supporting the local community and proactive in doing so. The practice had a Christian foundation but did not impose beliefs on patients. Their ethos was to treat people equally and respect them as unique and important individuals.

The practice had strong links with the local church. We were told of a number of outreach events that were held. For example, in December members of the church came to the practice daily serving coffee and mince pies to patients. They had a concert night one evening in December to which patients were invited to attend. They took part in a local herb growing scheme. Herbs were grown in planters in the practice gardens and the community invited to help care and maintain them.

Within the practice boundary there was a local hostel for the homeless with which they had strong links. We heard an example of a homeless patient being supported by a GP to obtain accommodation. Staff had discussed what they could do to assist donating furniture and helped them to move in to their flat.

Care planning and involvement in decisions about care and treatment

Patients were encouraged and supported where possible to take responsibility for their conditions and to be involved in decisions about medication and other forms of treatment. For example, staff told us about the protocol that had recently been introduced for management of diabetes. Patients diagnosed with diabetes were invited to attend a planning appointment with a practice nurse. They were encouraged to set personal goals in the management of their condition, consider how these could best be achieved and how they might overcome any barriers to achieving them. Their plan and progress was then subject to regular review to ensure it remained effective. Easy read literature had been produced to help explain issues to patients in a simplistic manner. Additional time was allocated for these appointments to ensure patients had the opportunity to fully participate. Staff told us this approach was proving very effective and they were starting to introduce a similar protocol for management of other long term conditions.

Patients we spoke with on the day and those who completed CQC comment cards told us they felt listened to and that their opinion mattered. They said they felt well supported by staff. Treatment options were explained and appointments were not rushed. Patients confirmed they were always asked for their consent before any procedure or treatment was undertaken.

Translation services were available for patients who did not have English as a first language. There were a number of refugees and asylum seekers within the patient population and we were told the translation service was regularly used.

Good

Are services caring?

In the patient survey information we reviewed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The most recent data available from the national patient survey showed that 76% of respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. 93% of respondents said they had confidence and trust in the last GP they saw or spoke to. 89% of respondents said the last GP they saw or spoke to was good at both listening to them and giving them enough time.

Patient/carer support to cope emotionally with care and treatment

The practice had a proactive approach to engaging with the local community and supporting patients to cope emotionally. Notices in the waiting room signposted patients to a number of support groups and organisations. One noticeboard was dedicated to information for carers, for example, signposts to Macmillan support, the Asian Carers Group, Blackburn and Darwen Carers Service, and a local organisation for young carers aged 10 to 17 years. Another noticeboard was dedicated to community issues with information about the local community church and advertisement of a forthcoming church fair. Where appropriate the practice was able to refer patients to a well-being service run by Blackburn and Darwen Council. The service was able to signpost or support patients with access to services and / or behaviour change in relation to a range of issues such as housing issues, debt advice, low level anxiety and stress, worklessness initiatives and volunteering opportunities.

The practice produced a quarterly newsletter. The most recent Autumn/Winter 2014 edition included articles signposting patients to the availability of a Befriending Service run locally by Age UK and a Dementia Café in Blackburn Town Centre open for carers and those diagnosed with dementia.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice offered a number of enhanced services to benefit their patients such as minor surgery, drugs misuse, chlamydia testing, childhood vaccinations and health checks. The practice took part in a number of local and national initiatives to extend and / or improve services. These included local improvement schemes focusing on access and quality of services, cancer detection rates, dementia screening and support, and provision of stop smoking services. They also participated in schemes to avoid unplanned admissions to hospital and to promote vaccination against childhood seasonal flu, shingles, meningitis C and MMR.

The practice primarily provided health care services to the vulnerable residents of the Shadsworth Estate. There were high levels of deprivation and unemployment amongst the patient population and a high prevalence of single parent families. The practice had a good understanding of the demographics of the area it served and was responsive to meeting patients' needs. There were high levels of engagement with other healthcare services and support organisations in the area to assist them to provide timely and effective support as required.

Examples included referral of patients to a well-being service run by Blackburn and Darwen Borough Council for exercise referral, falls prevention, weight management or support with behaviour and lifestyle changes such as reducing alcohol consumption, healthy eating, worklessness and volunteering initiatives. The practice worked closely with charitable organisations such as Christians Against Poverty and WISH. Patients were referred to Christians Against Poverty for help with matters such as debt management advice and food bank vouchers. WISH is a national charity that works with women with mental health needs in prison, hospital and the community.

Staff attached to the practice included district nurses, health visitors, mental health counsellors and a substance abuse team.

We spoke with the Chair of the Patient Participation Group (PPG). They told us the practice listened to feedback from the group and tried to implement changes where possible. For example, at the suggestion of the PPG there had been a change made to the practice opening hours.

Tackling inequity and promoting equality

The practice was opened in 1988 with a vision to provide excellent primary health care to those living in a deprived community who were substantially disadvantaged by health inequalities. This remained a fundamental value of the practice. We were shown a report that had been commissioned by the practice in 2009 for the purpose of considering how they could best identify hard to reach groups in the locality and ensure equality of access for them. The practice had adopted a wide definition of hard to reach groups and devised a strategy in relation to each. Hard to reach groups in the locality included: people from lower socio economic groups; working lone parents; unemployed people; black, minority and ethnic communities; people with hearing and/or visual loss; gay and lesbian people; lone pensioners; asylum seekers and refugees; homeless people; people with a learning disability; drug and alcohol users; and teenagers. The strategy was kept under review to ensure it remained effective. The practice had identified that these hard to reach groups made up 90% of the patient population.

The practice had a comprehensive Equality and Diversity Policy. This was up to date having last been reviewed in May 2014.

There was a large car park with allocated disabled parking. From the car park there was level entry to the surgery through electronic doors to facilitate wheelchair and pram access. All rooms used by patients were on the ground floor. Disabled toilets and baby change facilities were available. There was a lowered counter by the reception desk which could be used by patients in wheelchairs. The waiting area was spacious and corridors were sufficiently wide to accommodate wheelchairs and pram access.

An audio loop was available for patients who were hard of hearing. Staff knew how to access an interpreter to benefit patients for whom English was not the first language if required.

Access to the service

The practice opening hours were 8.30am to 6.30pm Monday to Friday with extended opening hours on

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Mondays until 8.15pm. During extended opening hours appointments were available with both GPs and nurses. When the practice was closed the care and treatment needs of patients were met by an out of hour's service.

Patients were able to book appointments in person, online or by telephone. Same day appointments were available for patients in emergencies and each day the practice appointment schedule included some availability to accommodate these.

We saw that in June 2014 the practice had carried out an audit of access to GP appointments. All sites within the Cornerstone Practice took part in a two week audit of capacity and demand. All appointment requests had been recorded and the appropriateness of GP and nurse practitioner appointments explored. We saw that the practice had identified and implemented actions that could be taken to improve systems as a result. At Dr AJM Murdoch's Practice the number of book on the day appointments available had been increased on Mondays. The practice was monitoring the progress and dates for further audits had been set in order to track improvements and respond accordingly.

Home visits were available for patients who were housebound or too ill to attend the practice. One GP took responsibility for review and allocation of requests for home visits, sharing them out amongst the GP team. GPs had portable electronic systems that enabled them to have full access patient records whilst on home visits.

Nurses visited housebound patients for annual chronic disease management. Clinicians also attended local care and nursing homes, as well as sheltered accommodations to offer flu and shingles vaccinations to registered patients irrespective of whether they were housebound or not.

The practice had a high percentage of missed appointments where patients failed to attend and this was currently under review. The matter had been the subject of discussion with the practice participation group. GPs were acutely aware that many patients faced challenging circumstances and had chaotic lifestyles and there was a reluctance to remove patients from the list for repeated failure to attend. Instead they were exploring alternative ways in which the problem might be reduced. For example, searching the patient records to identify those who frequently failed to attend and alerting their named GP who could then decide the most appropriate way to improve attendance for that individual.

Reception staff were proactive in trying to reduce missed appointments. If they saw the name of a patient who frequently missed appointments on the list they would try to make contact in advance of the due time to remind them. Nurses utilised any missed appointment time well by also reviewing lists and initiating contact with patients to remind them and follow up on any non-attendance.

The practice had a very informative practice leaflet outlining the staff, opening times and the expectations of the practice. This information was also available on their website.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. The practice had produced a leaflet which explained the complaints policy and process. Copies were available to patients in reception. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We saw the summary of the complaints received since October 2013. The summary provided a comprehensive record of the complaint, details of the investigation, action taken to address and resolve the issue, and any learning points identified. Complaints were discussed at the practice governance meetings and shared with staff as appropriate. The practice had systems in place to deal with any verbal indications of dissatisfaction as well as any written complaints received. Reception staff were aware of the process they should follow to ensure any verbal expression of dissatisfaction was recorded and reported for consideration.

We looked at three complaints that had been received. We saw these had been thoroughly investigated and the patient communicated with throughout the process. We saw complaints had been handled in a timely manner. In some instances the practice invited the complainant to a meeting to discuss the matter face to face and listen to

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

their concerns. Where a complaint was made on behalf of another the practice made checks to ensure the patient themselves consented to the third party acting on their behalf.

On conclusion of an investigation the patient was sent a letter explaining the steps that had been taken and the outcome. We saw the letter advised patients that if they remained dissatisfied with the outcome they had the right to refer the matter onwards, for example, to the Parliamentary Health Service Ombudsman.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The stated aims and objectives of the service were: provision of excellent, whole person centred care in a relaxed, friendly atmosphere; work with and alongside other health and social care organisations; focus upon serving those living in deprived communities disadvantaged by health inequalities; equal treatment and respect for all patients; and provision of training and development opportunities for all staff.

We found that staff knew and understood the practice vision and values, and what their responsibilities were in relation to these.

Governance arrangements

We found there was a strong governance structure in place. The practice had a number of policies and procedures in place to govern activity. These were available to staff on the practice intranet and were readily accessible. We viewed a number of policies and procedures and saw that they were reviewed annually and up to date.

The practice held regular governance meetings where matters such as performance, quality and risks were discussed. All meetings were recorded. Having minutes which outline the content of meetings helps improve governance mechanisms and minimise the risk of staff misinformation or error.

All staff were included in areas of responsibility such as monitoring appointments and introduction of systems to improve the smooth running of the practice, for example, working to reduce the number of missed appointments.

The practice used the Quality and Outcomes Framework (QOF) to measure their clinical performance. The QOF data available for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly practice meetings to ensure outcomes were maintained or improved upon.

The practice had completed a number of clinical audits including prescribing of diclofenac, bowel cancer screening and diagnosis of chronic obstructive pulmonary disease. We found that when audit cycles were completed any actions identified as a result were implemented and learning shared with staff as appropriate.

The practice had robust arrangements for identifying, recording and managing risks, for example, in relation to health and safety issues.

In 2012 the practice achieved the Quality Practice Award by the Royal College of General Practitioners, which remains valid for five years.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there were named GP leads for matters such as prescribing and safeguarding, and there was a lead nurse for infection control and the facilities manager lead on matters relating to the premises. Reporting lines were clearly defined and understood. Staff we spoke with understood their roles and were clear about the boundaries of their abilities. They were aware of each other's responsibilities and who to approach to feedback or request information.

Staff told us they felt well supported and valued. They followed the vision and values of the practice which were very clear. There was an open and honest culture. There was a regular programme of team meetings. Staff told us they had opportunity, and felt comfortable, in raising any issues at them. Clinical, administrative and reception staff all encompassed the concepts of compassion, dignity, respect and equality. They welcomed input from patients and acted upon feedback.

The practice had a comprehensive range of policies and procedures in place to support staff, for example, policies on equal opportunities and whistleblowing. These were readily accessible to staff and staff we spoke with knew where to find them.

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

The Cornerstone Practice had an active patient participation group (PPG) which was associated to the National Association for Patient Participation. All patients were invited to join the group. We saw posters about the PPG in the waiting room at Dr AJM Murdoch's Practice and information was posted on the website. There was one PPG

Are services well-led?

Good

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

to represent the interests of patients at all three sites within the Cornerstone Practice. The site manager at each location acted as a named contact for patients in relation to PPG matters at individual sites.

We looked at the PPG's annual report which was published in March 2014. Each year the practice carried out a patient satisfaction survey across all sites. The PPG had been actively involved in this process. We saw that PPG members had been asked for suggestions for the survey questions, responses had been collated and used to produce the questionnaire. The last survey had been completed in November 2013. Survey questions had included levels of satisfaction with the appointment system, premises, prescription service, time spent with the GP or nurse, and the reception staff. The results had been analysed by individual site and across the whole group to identify any common themes or trends. The findings were reported back to the PPG for discussion and an action plan agreed. The results were also published on the practice website.

The Chair of the PPG said the practice listened to their views and was receptive to feedback. As a result of PPG feedback the opening hours at Dr AJM Murdoch's Practice had been extended on Monday evenings. Overall feedback from the patient survey was good and patients had commented that they were happy with their care and the staff at all sites. The main negative theme from the patient comments was the length of time patients waited in the waiting room to see their GP. The Chair told us this was currently the subject of discussion with the PPG to establish the best way to address it. Another theme had been difficulty patients at Dr AJM Murdoch's Practice experienced in trying to make contact with the practice by telephone. The action plan showed that a new telephone system had been installed and on-going monitoring was being undertaken.

Patients were also able to offer feedback to the practice through the suggestions box in reception or the complaints process.

The practice gathered feedback from staff through appraisals and staff meetings. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy in place which was readily accessible to staff on the intranet.

Whistleblowing is defined as the disclosure by an employee of confidential information, which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace be it of the employer or a fellow employee.

Management lead through learning and improvement

The practice had a clear understanding and commitment to the needs of staff. There were good development opportunities. We found there was a willingness to invest in people and develop existing staff wherever possible, providing opportunities for further qualification and skills. For example, the lead nurse was working towards qualification as an advanced nurse practitioner. Both the practice and site managers had recently undertaken some post graduate management and leadership qualification. There were several members of staff who had joined the Cornerstone Practice in a particular role and subsequently achieved promotion to another. The practice was a training practice for doctors wishing to become GPs. They also participated in an apprenticeship scheme offering apprentices in medical administration work a training experience to prepare them for work. The first apprentice to join the practice had completed their training and been offered permanent employment. At the time of our inspection a second apprentice was in training with the team.

Newly employed staff completed a period of induction. Learning objectives for existing staff were discussed during annual appraisal and mandatory training was role relevant. Some training was carried out using e-learning and some through face to face contact.

The practice completed reviews of significant events and other incidents. Practice documentation showed clear evidence of learning being shared across the practice.

The Cornerstone Practice had a comprehensive schedule of meetings that enabled clinicians to discuss clinical practice and share learning with their colleagues and peers at Dr AJM Murdoch's Practice and across the whole group. There was an equivalent programme of meetings for non-clinical staff and opportunities for the whole staff team to get together. All meetings were minuted. GPs and nurses also had opportunities to attend meetings organised by the Clinical Commissioning Group and share learning with their respective peers.