Laurel House Surgery

Quality Report

12 Albert Road
Tamworth
Staffordshire
B79 7JN
Tel: 01827 69283
Website: www.laurelhousesurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Laurel House Surgery on 18 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it difficult to get through to the practice on the telephone to book an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients which it acted on.

We saw one area of outstanding practice:

Summary of findings

- The practice manager had developed a comprehensive electronic system to record, monitor and respond to clinical and non-clinical risks to patients and staff at the practice. The practice manager used the system to draw together all identified risks to patients and the practice. This was used to provide an overarching plan and framework of what the practice was doing well, where it needed to improve and what they would do to achieve this.

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

Importantly the provider should:

- Review the telephone access to the practice for patients trying to book appointments.

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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed some patient outcomes were at or above average for the region. However, it was below the regional average in managing long term conditions such as diabetes. There was an action plan in place to address this. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it difficult to get through on the telephone to book an appointment but spoke positively about the 'sit and wait' open access morning surgery. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received inductions, regular performance reviews and attended staff meetings

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, preventing avoidable hospital admissions and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had a named GP to provide continuity of care. The practice was below the regional average in managing long term conditions such as diabetes however there was an action plan in place to address this. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a child protection plan in place. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

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

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including vulnerable adults and patients with a learning disability. The practice worked with district and palliative care nurses to carry out annual health checks for their most vulnerable patients. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Quality Outcomes Framework (QOF) data from April 2013 to April 2014 showed that 100% of people experiencing poor mental health had an agreed care plan in place. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

All of the nine patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 58 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were mainly positive. Patients told us the staff were professional, efficient, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Several patients told us how some of the GPs went the extra mile to ensure they received the care that they needed. Patients told us that the practice was always clean and tidy. There was a common theme however regarding access to appointments. Patients told us they experienced problems getting through to the practice on the telephone to make an appointment.

The results from the National Patient Survey showed that 86% of patients said that their overall experience of the practice was good or very good and that 83% of patients would recommend the practice to someone new to the area. This was in line with the CCG regional average.

Areas for improvement

Action the service SHOULD take to improve

The provider should review the telephone access to the practice for patients trying to book appointments.

Outstanding practice

The practice manager had developed a comprehensive electronic system to record, monitor and respond to clinical and non-clinical risks to patients and staff at the practice. We saw that the practice manager used the system to draw together all identified risks to patients and the practice. This was used to provide an overarching plan and framework of what the practice was doing well, where it needed to improve and what they would do to achieve this.

Laurel House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Laurel House Surgery

Laurel House Surgery was originally founded around 1910 and offers a variety of facilities. The main practice is based in Tamworth and there is a branch practice in Fazeley on the outskirts of Tamworth. Laurel House Surgery is a two storey building with car parking facilities and step free access to the automatic door at the side entrance to the building.

There are four treatment rooms and four consulting rooms with an associated waiting area on the ground floor. On the first floor there are a further five consulting rooms.

A team of seven GP partners; three salaried GPs; four practice nurses; a health care assistant; a practice and assistant practice manager; 13 receptionists and six administrators provide care and treatment for approximately 13300 patients. Six female and four male GPs provide care for patients at the practice. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to Staffordshire Doctors Urgent Care service when the practice is closed.

Why we carried out this inspection

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

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

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

Detailed findings

- 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 carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a representative of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We also spoke with representatives from two of care homes the practice provided care and support for people living there. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 18 March 2015 at the practice. During our inspection we spoke with three GP partners; a salaried GP; a practice nurse and a health care assistant; two receptionists; the practice manager; two administrative staff member and nine patients. We observed how patients were cared for. We reviewed 58 comment cards where patients and members of the public shared 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 patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents, significant events and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a policy in place for staff to refer to when reporting, recording and monitoring adverse incidents, near misses, significant events and good practice. There were records of significant events that had occurred during the last six years and we were able to review these. We saw that significant events were discussed regularly at business and governance meetings and were a standard item on the practice meeting agenda. We saw minutes from these meetings that confirmed this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. The practice manager showed us the system they used to manage and monitor incidents and significant events. We tracked 10 significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of significant events. For example, following an incident whereby an ambulance was unable to find the practice, concerns were raised with the local ambulance service. Practice staff were also made aware of the importance of informing the ambulance service exactly where the practice was located to avoid an incident of this type occurring again.

There was a policy in place for the handling of national patient safety alerts which identified who was responsible for the dissemination of the alerts to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding for children & vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to an appropriate level and could demonstrate they had the necessary training to enable them to fulfil this role. Some of the staff we spoke with were not aware of who the GP safeguarding lead was within the practice but all told us they would speak to a GP immediately if they had any safeguarding concerns.

The practice held a list of vulnerable adults and children who were registered with the practice. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. The practice held monthly meetings with the health visitor to discuss children who were at risk of harm. We saw minutes from these meetings that confirmed this.

There was a chaperone policy which was accessible on the practice website. Signs informing patients of their right to a chaperone were displayed in the waiting room and on consulting room doors. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff had been trained to be a chaperone. However, staff told us that one of the GPs asked them to stand

outside the curtain during an intimate examination which meant they could not fully observe what was happening. We raised this with the practice manager and senior partner on the day of our inspection. They told us they would address this issue with the GP and staff who chaperoned. Within four working days the provider forwarded evidence to us that demonstrated this had been addressed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We looked at daily schedules which demonstrated that the practice staff followed the policy.

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.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. We saw that they were stored securely at all times.

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

Cleanliness and infection control

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

The practice had two leads for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All the staff had received training about infection control specific to their role and received annual updates. We saw evidence that infection control audits were carried out three monthly at the practice. We saw that where improvements were identified action had been taken in a timely manner. For example, the need to replace the pillows used at the practice had been identified during the last infection control audit. We saw that this had been completed and the date of completion was recorded in the practice's electronic risk management system.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they used these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that appropriate staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that a legionella risk assessment had been completed in November 2014 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

Good

Are services safe?

We saw records that demonstrated all portable electrical equipment had been tested in December 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in April 2014 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices. We saw there was equipment at the practice that contained mercury. Mercury is a hazardous substance and is subject to the Control of Substances Hazardous to Health Regulations 2002. We saw that a mercury spillage kit was available to keep patients and staff safe in the event of a mercury spillage.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, qualifications and registration with the appropriate professional body.

Disclosure and Barring Service (DBS) checks to ensure that clinical staff were suitable to work with patients had been carried out. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. A risk assessment had been carried out by the practice that identified administrative staff such as receptionists did not require DBS checks to be completed.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned six to eight weeks in advance to ensure adequate staffing levels were maintained.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that annual and monthly checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; emergency lighting tests; an asbestos management survey and a health and safety assessment of the physical safety of the building. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

The practice manager had developed a comprehensive electronic system to record, monitor and respond to clinical and non-clinical risks to patients and staff at the practice. We saw that the practice manager used the system to draw together all identified risks to patients and the practice. This was used to provide an overarching plan and framework of what the practice was doing well, where it needed to improve and what they would do to achieve this.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required. We spoke with two parents of young children on the day of our inspection who confirmed this. The practice used a risk assessment tool to help them to identify and support the two per cent most vulnerable patients in their practice population. To support these patients, the practice worked closely with attached staff such as district nurses, palliative care nurses and staff from the Integrated Local Care Team (ILCT). The ILCT is a team of health and social care staff such as community matrons and social workers. We saw minutes that demonstrated that these multidisciplinary meetings were held six weekly to support these vulnerable patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen, airway management equipment for both adults and children, and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a

Good

Are services safe?

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included the risk of flood; loss of information technology; loss of staff; loss of telephone communications and the loss of domestic services. We saw that the business continuity plan included short and long term plans to manage these situations. The document also contained relevant contact details for staff to refer to.

A fire risk assessment of the practice had been carried out in October 2014 that included the actions required to maintain fire safety. Records showed that staff were up to date with fire training and that monthly fire alarm checks and annual fire drills were carried out at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, we saw that patients with suspected cancers were referred and seen within two weeks in line with NICE guidelines.

As part of the action plan, GPs were to take the lead in specialist clinical areas such as diabetes, heart disease and asthma. The recruitment of GPs to the practice had made this difficult previously but the practice had recently recruited two GPs one of whom had an interest in diabetes. The practice nurses supported the GPs in the management of patients with long term conditions. We saw evidence that they had completed additional courses in long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD) to support them to carry out this work. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at the quality and outcomes framework (QOF) data for 2013 – 2014 and saw that the practice was above the national average for antibiotic prescribing. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measure. The GP partners we spoke with were aware of this and showed us audits carried out with the Clinical Commissioning Group (CCG) pharmacist that identified where their prescribing was high. We saw that an action plan was in place to address this. The practice used a nationally recognised risk assessment tool to identify frail and elderly patients with complex needs. We saw they worked closely with the Integrated Local Care Team (ILCT) to support patients with long-term complex needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The practice showed us four clinical audits that had been undertaken over the last 18 months. One of the audits was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of male patients with prostate cancer had been carried out. The aim of the audit was to identify any patients with prostate cancer who had not had the prostate specific antigen (PSA) blood test carried out within the last 12 months to monitor the growth of their prostate cancer. The first audit demonstrated that 17 patients were not up to date with this blood test. Following the audit, these patients were reviewed by their GP. The audit was repeated 11 months later. This audit demonstrated that 11 patients had not received the blood test showing an improvement in the on-going follow up of patients with a history of prostate cancer.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We saw that the practice did not meet the minimum clinical standards in six areas. For example, the percentage of patients with diabetes on the practice register with a record of a foot examination within the preceding 12 months was 69% compared with a national average of 83%. We saw that the practice had put an action plan in place to improve these clinical standards. This included a reconfiguration of their nursing team; supporting a practice nurse to complete

Good

Are services effective?

(for example, treatment is effective)

a nationally recognised course in the management of patients with diabetes; the employment of a health care assistant to assist the practice nurses and the recruitment of two GPs one of whom had a special interest in diabetes.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patients' needs.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of 23 patients and alerts within the clinical computer system making clinical staff aware of their additional needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff told us and we saw records that all staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example a practice nurse had recently completed a nationally recognised course for the management of patients with diabetes. The practice manager had developed an electronic system that captured the learning and training needs identified in staff appraisals. They used this information for the future planning of the service.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and cervical screening. Those with extended roles such as the management of long term conditions were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

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

The practice was commissioned for the enhanced service, admissions avoidance strategy, and had a process in place to prevent patient avoidable hospital admissions. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the system was working well and that 235 patients had been identified by the practice as high risk. The practice manager told us that all these patients had an admissions avoidance care plan in place that had been shared with patients. Representatives from the two care homes for older people that we spoke with confirmed that the patients living at their home and registered with Laurel House Surgery did have these care plans in place. The practice held multidisciplinary team meetings to discuss the needs of these patients. We saw minutes from these meetings that demonstrated the practice met six weekly with other professionals such as community matrons and palliative care and district nurses to review the care these patients needed.

Good

Are services effective?

(for example, treatment is effective)

The practice held monthly meetings with the health visitor to discuss children who were at risk of harm. We saw minutes from these meetings that confirmed this.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice used shared notes to share concerns with the local GP out-of-hours provider. The practice used the Choose and Book system to refer patients for hospital appointments. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record Emis web to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Although staff had not received formal training in the Mental Capacity Act (MCA) 2005, we found that staff were aware of it and their duties in fulfilling it. We saw that one of the GP partners was booked on MCA training on 24 March 2015. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt cardio-pulmonary resuscitation (DNARCPR) decisions. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. We saw that there were formal consent forms for patients to sign when receiving minor surgery at the practice. The practice had carried out an audit which demonstrated that the consent forms were used appropriately. Nursing staff described to us how they ensured that parents were provided with information to enable them to make an informed decision when providing consent for their child's immunisations. We saw that parents signed formal consent forms consenting to the immunisation of their child.

Health promotion and prevention

It was practice policy to offer a health check with a practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional CCG average in the uptake of childhood immunisations. A GP, practice nurse and health visitor worked collaboratively to provide a weekly one stop baby clinic. Here babies received their eight week development check with the GP and their immunisations with the practice nurse. Parents also had access to the health visitor to discuss any concerns about their baby. The practice also offered a family planning service at the practice and confidential chlamydia screening for young people.

We spoke with a practice nurse who told us how patients experiencing poor mental health and patients with a learning disability received an annual health review. We saw that it was a two part process involving the practice nurse for a general health assessment and healthy living advice followed by an appointment with the GP for a formal health and medication review. The practice nurse showed us easy read leaflets that they used to help patients with a learning disability to understand their care and treatment. These included easy read advice leaflets for breast or cervical screening, testicular examination and

Good

Are services effective?

(for example, treatment is effective)

lifestyle advice leaflets for teenagers covering sexual health, relationships and personal hygiene. The practice nurse told us how patients and their carers had responded positively to these.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years and travel vaccinations when needed. Patients over 75 years of age had a named GP to provide continuity of care.

There were systems in place to support the early identification of cancers. The practice carried out cervical smears for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 84% which was above the national target of 80%. The practice also proactively encouraged abdominal aortic aneurysm screening for men over 65 years of age. The Abdominal Aortic Aneurysm Screening Programme is a systematic national population-based screening programme that aims to reduce deaths from ruptured abdominal aortic aneurysms through early detection, appropriate monitoring and treatment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 124 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 295 patients undertaken with the support of the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 86% of respondents said that their overall experience was good or very good and 83% of respondents would recommend the practice to someone new in the area. These results were in line with the regional Clinical Commissioning Group (CCG) average. The practice was above the CCG regional average for its satisfaction scores on consultations with doctors and nurses. Ninety-two per cent of respondents said the GP was good at listening to them and 92% said the GP gave them enough time. Ninety-two per cent of respondents said the nurse was good at listening to them and 95% said the nurse gave them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 58 completed cards which were mainly positive about the service experienced. Patients told us the staff were professional, efficient, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Several patients told us how some of the GPs went the extra mile to ensure they received the care that they needed. There was a common theme however regarding telephone access to appointments. Patients told us they experienced problems getting through to the practice on the telephone to make an appointment. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a sign informing patients to stand back from the reception desk. The practice switchboard was located at the reception desk. Reception staff that we spoke with were aware of the difficulties this presented but had systems in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a telephone away from the reception area. We saw there was a notice informing mothers that if they required privacy to breastfeed their baby that a room would be provided.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice on the practice website and in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

The practice provided care and support to a local women's refuge. They told us how they supported these patients to access the practice without fear of stigma or prejudice. Patients with a learning disability were offered longer appointments to ensure they were given adequate time to discuss and understand their treatment. We spoke with the carer of a person with a learning disability on the day of our inspection who confirmed they were provided with longer appointments.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient

survey showed 83% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above the CCG regional average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on most of the comment cards we received was also positive and aligned with these views.

We spoke with a practice nurse who told us how patients with a learning disability received an annual health review. We saw that it was a two part process involving the practice nurse for a general health assessment and healthy living advice followed by an appointment with the GP for a formal health and medication review. The practice nurse showed us easy read leaflets that they used to help patients with a learning disability to understand their care and treatment. These included easy read advice leaflets for breast or cervical screening, testicular examination and lifestyle advice leaflets for teenagers covering sexual health, relationships and personal hygiene. The practice nurse told us how patients and their carers had responded positively to these.

We spoke with representatives from two nursing homes for older people where the practice provided care and treatment for patients. They told us that all the patients living there who were registered with Laurel House Surgery had a care plan in place and received annual health reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNARCPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others. We saw that there was a policy in place at the practice to support GPs in these decisions. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands

Staff told us that translation services were available for patients who did not have English as a first language to ensure that they fully understood the care and treatment options available to them.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 89% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional CCG average of 84%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. Patients were asked to inform reception staff if they were a carer or were cared for by another person. This information was then recorded in the patients' notes to alert the practice staff to the possible needs of this role. They also signposted carers to the local carers' organisations who provided advice and assistance to carers if requested.

One of the GPs we spoke with described to us how they supported patients known to them who had suffered a bereavement. They told us that they provided a home visit and sign posted patients to support services such as CRUISE and St Giles bereavement support. They provided one to one consultations if required. We spoke with a patient on the day of our inspection who had suffered a bereavement. They were overwhelmingly positive about the bereavement care and support they had received from the practice and the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. One of the GP partners from the practice attended these meetings and disseminated feedback to the practice at the weekly business meetings.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, following feedback from the PPG the practice had introduced an open access 'sit and wait' morning service to help to alleviate the demand for patient appointments.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed the equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated by each member of staff.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground and first floors of the building with services for patients provided on both floors. A lift was not available at the practice but the practice manager told us that any patients who had a mobility difficulty were seen in a downstairs consulting room. On the day of our inspection we observed that a receptionist offered a patient with a walking stick a consultation room downstairs.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included step free access to an electronic door at the side of the main entrance to the practice; disabled toilet facilities and additional hand rails at the point of entrance. There was no designated parking for patients with mobility difficulties. We saw that patients with a disabled blue badge parked outside the practice on the double yellow lines. A hearing loop facility was available for those patients/visitors with a hearing impairment. The practice also had links with a local college who provided a signing service if needed. We saw that there was clear signage for visually impaired patients.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to several house bound older patients and patients living in care homes. Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice and a health promotion advice was provided in an easy read format by the practice nurse.

The practice had a small transient population as they provided care to a local women's refuge and a foster parent who fostered teenagers some of whom had been refugees from other countries. The practice informed us they had a temporary patient's service for anyone staying within their practice boundary. This was available for all patients irrespective of culture, religion or sexual preference. They told us that patients of 'no fixed abode' were supported to register with the practice. They told us the practice used the practice address when referring these patients to other services to provide a point of contact.

Access to the service

The practice provided fixed patient lists for GPs to provide continuity of care for patients. Whilst patients valued this they told us that they often had to wait too long to see their named GP. Appointments were available from 8am to 6.30 pm on weekdays. On Tuesdays the practice opened 8.30am until 8pm to meet the needs of working age patients and school children. When the practice was closed patients were transferred to Staffordshire Doctor Urgent Care out of hours service. Patients could book appointments up to seven weeks in advance. Bookable on the day

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments were also available and GPs provided telephone consultations. The practice also offered open access 'sit and wait' appointments Monday to Friday between 9am – 11am. These were appointments for patients with urgent care needs. Staff told us this service was very well used. The practice had identified that the greatest demand for this service was on Monday mornings. To meet this demand the number of GPs providing this service had been increased at this busy time.

Information from the national patient survey showed that 50% of respondents found it easy to get through on the phone and 59% of respondents described their experience of making an appointment as good or very good. These results were below the local CCG average of 73% and 75% respectfully. The practice's own patient survey, patients we spoke with on the day of our inspection and the comment cards we reviewed also supported this view. We saw that an action plan had been put in place to address this issue. We saw that the practice was considering changing their telephone system and as an interim measure two switchboard operators operated the switchboard during the busiest times. On-line bookable appointments had also been introduced and patients accessed these through the practice website.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, patients were diverted to the Staffordshire Doctor Urgent Care out of hours service.

Staff we spoke with told us that children were always provided with an on the day appointment if required. We spoke with two parents of young children on the day of our inspection that confirmed this. Patients with a learning disability were offered longer appointments to ensure they were given adequate time to discuss and understand their treatment. We spoke with the carer of a person with a learning disability on the day of our inspection who confirmed they were provided with longer appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that there was a practice leaflet informing patients how to complain both to the practice and to the other authorities such as the Care Quality Commission, NHS England and the Ombudsman. Patients we spoke with were aware of the process to follow if they wished to make a complaint. The complaints policy was also displayed on the practice website and in the reception area.

We looked at 12 complaints received between 1 April 2014 and the day of our inspection. We found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice/governance meeting minutes that demonstrated that complaints were a regular agenda item and that learning from them was shared with staff. This enabled staff to learn and contribute to any improvement action that might have been required. However, we saw that when patients emailed their complaints to the practice that a responsive telephone call was made to the patient but the details of this call had not been recorded.

The practice reviewed complaints annually to detect themes or trends. We looked at their annual complaints review report for 2014 -2015. The practice had identified that there was a trend in the number of complaints regarding access to appointments. We saw that the practice had discussed their action plan with the PPG and some measures to address this had been put in place. A change to the telephone system used at the practice had also been incorporated into the practice's five year business development and strategy plan.

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. Their mission statement was, 'To improve the health, well-being and lives of those entrusted to our care'. Their values included, to provide a high quality service; to be innovative; to learn from others; to embrace change; to share good practice with others and to appreciate and look after their staff. We found details of the vision and practice values were part of the practice's five year business development and strategy plan.

We spoke with 11 members of staff on the day of our inspection and they all demonstrated and understood the vision and values and knew what their responsibilities were in relation to these. Prior to our inspection we spoke with representatives from two care homes where the practice provided care and support to patients and they confirmed that the practice worked in line with these values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at 14 of these policies and procedures and saw that all of these policies had been reviewed six to 12 monthly and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there were two lead nurses for infection control, a GP clinical lead for nurse training and a lead for safeguarding children and vulnerable adults. The practice was in the process of developing clinical leads for long term conditions such as diabetes and asthma. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing slightly below national standards with a practice value of 95.2% compared with a national value of 96.4%. We saw that QOF data was regularly discussed at monthly governance meetings. We saw that action plans had been produced to maintain or improve patient outcomes. This included a reconfiguration of the nursing team, the employment of a health care assistant to assist the practice nurses in the monitoring of patients with long term conditions and the allocation for each QOF area to a dedicated GP.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of male patients with prostate cancer had been carried out. The aim of the audit was to identify any patients with prostate cancer who had not had the prostate specific antigen (PSA) blood test carried out within the last 12 months to monitor the growth of their prostate cancer. The first audit demonstrated that 17 patients were not up to date with this blood test. Following the audit, these patients were reviewed by their GP. The audit was repeated 11 months later. This audit demonstrated that 11 patients had not received the blood test showing an improvement in the on-going follow up of patients with a history of prostate cancer.

The practice had arrangements for identifying, recording and managing risks. The practice manager had developed a comprehensive electronic system to record, monitor and respond to clinical and non-clinical risks to patients and staff at the practice. We saw that the practice manager used the system to draw together all identified risks to patients and the practice. This was used to provide an overarching plan and framework of what the practice was doing well, where it needed to improve and what they would do to achieve this.

The practice held governance meetings every two months. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that practice meetings were regularly held. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment, lone working and health and safety which were in place to support staff. We were shown

Are services well-led?

Good

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

the staff electronic handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistle blowing policy which was available to all staff to access by the practice's intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and saw that 63% of patients agreed telephone consultations would be useful. We saw as a result of this the practice had introduced telephone consultation appointments.

The practice had an active patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. A spokesperson from the PPG told us between three to seven PPG members attended the three monthly PPG meetings. Representatives were mainly of working age and included female and male members. The spokesperson told us that they had had conversations with the practice regarding poor telephone access to the practice. The telephone system had not been updated but we saw the issue had been incorporated into the practice's five year business development and strategy plan for 2015 to 2016. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals took place on a 12 monthly basis and included a personal development plan. Staff told us they found the appraisals beneficial and that the practice was supportive of training. We saw that the practice manager had collated relevant points such as staff training and learning needs and these were incorporated into the practice's annual business plan.

The practice had completed reviews of significant events and other incidents and shared the learning from these with staff at practice meetings to ensure the practice improved outcomes for patients. For example, following an incident whereby an ambulance was unable to find the practice when called by practice staff for a patient who was unwell, concerns were raised with the local ambulance service. Practice staff were made aware of the importance of informing the ambulance service exactly where the practice was located to minimise the risk of an incident of this type occurring again.

We saw minutes from clinical and practice meetings that demonstrated the practice had discussed complaints after they had happened to learn and improve the service they provided to patients. Complaints were a standard agenda item on the practice meeting agenda. We saw that complaints were reviewed over time and trends identified and acted on.