Dr Guindy and Partners

Quality Report

Orchard Surgery
Knypersley Road
Norton In The Moors
Stoke On Trent
ST6 8HY
Tel: 01782 534241
Website: www.orchardsurgery.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

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 21 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found that the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice operated a telephone triage managed by the practice nurses, which enabled patients to access same day appointments.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- Staff were clear about their own roles and responsibilities, and felt valued, well supported and knew who to go to in the practice with any concerns.

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

The provider should:

- Complete a legionella risk assessment on completion of the improvement work to the nurses' room.
- Have a system to check stock levels and audit to ensure all medicines remain in date and safe to use.
- Obtain all required employment checks prior to employment of all new staff.
- Inform patients that they can request to speak with the receptionist in private if required.

Summary of findings

- Make the minutes of the patient participation group meetings available to patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. 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. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Data showed patient outcomes were at or above average for the locality. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the 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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients reported good access to the practice, and confirmed that they were usually offered a same day appointment when they telephoned. They could also book appointments in advance. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

Summary of findings

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice had identified vulnerable older patients and had developed individual care plans to support their care needs. These care plans were shared with the out of hour's provider, with the patient's permission. Influenza and shingles vaccinations were offered to older patients according to national guidance. Home visits for vaccinations were arranged for older patients who were housebound.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as diabetes and asthma. The nursing staff were supported by lead GPs for each long term condition. The practice maintained registers of patients with long term conditions. Disease management plans had been developed to support their care needs. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks. Staff were proactive in following up patients who did not make appointments for their reviews. For those patients with the most complex needs, the practice 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 families, children and young people. We saw that the practice provided services to meet the needs of this population group. Same day appointments were available through the triage system for children who were unwell. Staff were knowledgeable about how to safeguard children from the risk of abuse. Systems were in place to identify children who were at risk, and there was a good working relationship with the health visitors and school nurses attached to the practice. Appointments were available outside of school hours and the premises were suitable for children and babies. There were effective screening and vaccination programmes in place to support patients and health promotion advice was also provided. The percentage of children receiving the vaccines was generally in line with the average for the local clinical commissioning group. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice. New mothers and babies were offered post natal checks at the same time.

Summary of findings

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 who have recently retired and students). The practice offered a range of appointments which included on the day and pre-bookable appointments. The practice was pro-active in offering on line services as well as a full range of health promotion and screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 74 years old a health check with the health care assistant. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services. Staff told us that they supported patients living in care homes, people with substance misuse and people with a learning disability. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It informed vulnerable patients about how to access various support groups and voluntary organisations.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of the inspection. Patients were very satisfied with the service they received at the practice. They told us that the triage system worked well and they could get same day appointments. However, they told us they had to wait for pre-bookable appointments with a GP of their choice. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed 40 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection.

We saw that the comments were extremely positive. Patients said that they felt the practice offered an excellent service, and staff were considerate, helpful and caring.

We looked at the national GP Patient Survey published in December 2013. The survey found that 81% of Dr Guindy and Partners patients described their overall experience as good or very good, which was in the middle range of the national average. In addition, 72% of patients would recommend the practice to someone new to the area, which was also within the middle range of the national average.

Areas for improvement

Action the service SHOULD take to improve

- Complete a legionella risk assessment on completion of the improvement work to the nurses' room.
- Have a system to check stock levels and audit to ensure all medicines remain in date and safe to use.
- Obtain all required employment checks prior to employment of all new staff.
- Inform patients that they can request to speak with the receptionist in private, if required.
- Make the minutes of the patient participation group meetings available to patients.

Dr Guindy and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Dr Guindy and Partners

Dr Guindy and Partners (known as Orchard Surgery) is located in a two storey building in Norton on the Moors, Stoke on Trent. Services for patients are located on the ground floor. Dr Guindy and Partners serves the local population by providing general medical services.

Dr Guindy and Partners also have a branch practice (known as Endon Branch Surgery) in Endon, Stoke on Trent. Patients registered with the practice may visit either location to receive services. We did not visit the branch practice as part of this inspection.

The practice has four GP partners (two male and two female), two salaried GPs (both male) a practice manager, a nurse practitioner, three practice nurses, a health care assistant, and reception and administration staff. There are 10590 patients registered with the practice. The practice is open from 8am until 1pm and 2pm until 6pm Monday to Friday. The practice treats patients of all ages and provides a range of medical services. Approximately 25% of the practice population is aged 65 years and over.

The practice provides a number of clinics, for example long term condition management including asthma and diabetes. It offers child immunisations, minor surgery and travel health.

Dr Guindy and Partners has a General Medical Services contract.

Dr Guindy and Partners do not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

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

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

We carried out an announced visit on 21 November 2014. During our inspection we spoke with three GPs, a registrar, one practice nurse, the health care assistant, the practice manager, and five reception/administration staff. We spoke with eight patients who used the service about their experiences of the care they received. We reviewed 40 patient comment cards sharing their views and experiences of the practice. We also spoke with two representatives from the patient participation group and staff from two local care homes.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the reporting process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 15 months and we were able to review these. Significant events were a standing item at the monthly practice meeting and clinical team meeting. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. The practice manager told us that staff may discuss incidents verbally and then complete the form. We saw the system in place to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we found there had been a prescribing error where an item prescribed pre-operatively by the hospital for a patient, remained on the repeat prescription following the operation. This had arisen through poor communication and not following through instructions to check whether the medication was still required. A new system had been introduced to demonstrate when the required action had been taken. We saw that incidents were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with described the action they would take for alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

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

The practice had dedicated GPs appointed as the leads for safeguarding vulnerable adults and children who could demonstrate that they had the necessary training to enable them to fulfil this role. Staff were aware of which GPs were the safeguarding leads. They told us that if the leads were not available, they could go to the GP on call. Nursing staff were able to describe circumstances when they had raised safeguarding concerns with the GP leads, who had then taken appropriate action.

There was a chaperone policy, which was visible on the waiting room noticeboard. Members of the nursing staff team acted as chaperones when requested by the GP. Staff had received appropriate training, and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination and what to do if they had any concerns regarding the examination. Patients spoken with on the day of the inspection told us they were offered chaperones when intimate examinations took place.

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

Good

Are services safe?

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities. There was a system in place that highlighted patients with caring responsibilities. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for.

Staff told us they met with the health visitor every two weeks to discuss children who had child protection plans in place. They said that if a child did not attend for their immunisations after three invites; they would make a referral to the health visitor to follow up. The practice also received alerts from accident and emergency department at the hospital if a child had attended the department for a certain number of visits in a set period of time.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. The practice did not have any alternative arrangements for storage of vaccines if the electricity supply was interrupted, for example, at a local chemist or GP practice. The practice had validated cool boxes which were used for transporting vaccines.

We found that medicines were administered and stored correctly. We were told that there was a designated member of staff responsible for managing the medicines held in the practice. We checked the storage and stock control of the medicines held in the practice. We found that medicines were well organised and kept in locked cupboards. However a system was not in place to check or audit stock levels to ensure all medicines remained in date and were safe to use. However, all the medicines we checked were within their expiry dates.

Staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines kept in the nurses' room. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. We saw evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Systems were in place to check the identity and record the name of the person who collected the prescription from the practice, including pharmacies which offered a collection service. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by the Medicines Management Team from the local Clinical Commissioning Group. A member of the team visited weekly and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. For example, a check was carried out on patients over 65 years of age who were prescribed anti-inflammatory medicines to see if they were also prescribed medicines to prevent stomach ulcers. The electronic records demonstrated that these patients had been prescribed the required additional medication.

Cleanliness and infection control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy, and we observed this to be the case. We saw that there were cleaning schedules in place and up to date cleaning records.

The practice had a lead for infection control who acted as the point of contact for other staff. Training records demonstrated that staff had received infection control training. The practice had carried out an annual infection control audit in 2013 using the Infection Control Toolkit. We saw that improvements identified for action in the 2013 audit had been addressed. A further audit had been carried

out in 2014. The improvements identified in this audit were in the process of being addressed. We saw that training on infection control and hand washing had been arranged for all staff.

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.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received appropriate immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. One member of staff described how the policy had been implemented following a recent needle stick injury. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gel was available for patient use in the waiting room, and we observed patients using this.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice manager told us that a legionella risk assessment would be completed following the improvement work to the nurses' room.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. Most staff had worked at the practice for many years. We looked in the file of three members of staff who had recently been recruited. We saw that the majority of the appropriate checks had been carried out for two of these members of staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, one file did not contain all of the pre-employment checks. The practice manager told us this member of staff had originally been employed on a locum basis but had recently been given a permanent contract.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw that there was a rota system in place for all of the different staffing groups to ensure that enough staff were on duty. Staff told us that there was a minimum number of staff on the rota each day. Through auditing the number of calls through the triage system, it had been identified that Mondays, Wednesdays and Fridays were the busiest days, so additional staff were on duty on those days. Annual leave was limited to one member of staff from each team at any one time.

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. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. All risk assessments were updated on an annual basis. A health and safety audit had been carried, which produced a list of recommendations. The practice manager told us they were taking action to address the recommendations.

Staffing establishments were reviewed to keep patients safe and meet their needs. For example, only one member of staff from each team was allowed annual leave at any one time, and annual leave could only be taken once it had been agreed at the practice meeting.

Good

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice had started to use a risk assessment tool to help them to identify and support vulnerable patients near the end of their lives. This included closer working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers.

The GPs proactively managed the care of patients who were at high risk of admission. For example, patients with chronic lung conditions, at risk of falls and those patients who were terminally ill. The practice encouraged patients with chronic lung disease to stop smoking, attend pulmonary rehabilitation and attend for relevant immunisations. As a consequence, when comparing data with other practices in the locality, the practice had the lowest rate of accident and emergency admissions.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. For example, contact details of the utilities company if any utility failed. The practice manager told us arrangements were in place to use the branch practice if they were unable to access the building. The plan had been updated following an emergency situation at the practice in August 2014. Although the situation was managed safely, it highlighted a number of shortfalls in the procedure. As a consequence an emergency box containing contact details of utility suppliers and key staff was now kept in reception, contact details for staff had been updated and the need for fire drills considered. The business continuity plan was stored electronically on the computer system, and also off site.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training, with further training planned for 2015. The practice planned to undertaken emergency drills in the near future.

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 and from local commissioners. The practice nurse we spoke with told us that new guidance was discussed at clinical meetings. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The practice nurse told us they had recently attended a course on chronic obstructive pulmonary disease (chronic lung disease with one of the GPs. The practice was part of a stroke prevention initiative. They had worked with a lead cardiology nurse to audit the use of blood thinning medicines in patients with a particular medical condition, in order to prevent strokes. The practice had also completed a review of case notes for patients on non- steroidal anti-inflammatory (NSAIDs) medicines or aspirin. These medicines can cause bleeding of the stomach, and patients should be prescribed additional medicines to prevent this. We saw that patients over 65 years on NSAIDs had also been prescribed additional medicines. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 885.49 QOF points out a possible 900, which was higher than the national average. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice did not fall outside the normal range for any QOF (or other national) clinical targets. The practice had also signed up to the local Clinical Commissioning Group (CCG) Quality Improvement Framework (QIF). The QIF is underpinned by a learning and development programme, with workshops and best practice documents. The senior GP partner showed us data from the QIF of the practice's performance for prescribing of antibiotics. We saw that this was lower than the CCG average and demonstrated that the practice was proactive in monitoring the prescribing of medicines.

The practice showed us a number of clinical audits undertaken in recent years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example: the practice carried out an audit of patients with chronic obstructive pulmonary disease (COPD / lung disease). The purpose of the audit was to review management of the condition and admissions to hospital. Following the audit, patients were offered support through smoking cessation courses, pulmonary rehabilitation courses, and rescue medication packs at home. As a result, hospital admissions had reduced. Other examples included audits to check the management of patients with gout and management of patients with 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. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The GPs told us that in order to maximise the effectiveness of the medicine review appointment, appropriate blood tests were completed prior the appointment. The practice was supported by the medicines management team from the local CCG, who flagged up relevant medicine alerts and identified patients on this particular medicine. The information was then passed on to the GPs so that they could carry out a review.

Good

Are services effective?

(for example, treatment is effective)

The practice had achieved and implemented the gold standard framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had also started to develop a good working relationship with the 'Hospital at Home' service. This service promoted the care of children in their own home, rather than admission to hospital.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to or better than other services in the area. For example, the practice had a lower rate of outpatient referrals, accident and emergency rates for patients with chronic lung disease and antibiotic prescribing.

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 courses such as annual basic life support. We noted a good skill mix among the doctors with each GP taking a lead in various aspects of medicine at the practice. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

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 interpretation of spirometry results. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, spirometry and ear syringing. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma and diabetes were able to demonstrate that they had appropriate training to fulfil these roles. The nurse practitioner was an independent prescriber of medicines.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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 practice used an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician or trainee. Some information, such as discharge letters from hospital, was received directly into the system. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held regular multidisciplinary team meetings with the health visitor and the Integrated Local Care Team (ILCT) to discuss the needs of complex patients, for example children with a child protection plan in place or those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses, community matrons and social workers. Decisions about care planning were documented in the meeting minutes.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice monitored their referral rates for outpatients and compared these against other practices in the CCG locality. The data showed that when compared with other practices in the locality, the practice had the lowest outpatient referral rate. This was because the practice used the expertise within the practice, before making a referral.

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

Good

Are services effective?

(for example, treatment is effective)

record EMISWeb to coordinate, document and manage patients' care. All staff were fully trained on the system and had access to an EMISWeb handbook for additional support and guidance. 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

We saw that the practice had policies on consent, the Mental Capacity Act 2005, assessment of Gillick competence of children and young adults, and information around the Fraser guidelines. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. Staff with responsibility for prescribing contraception had attended appropriate courses on contraception and sexual health. The UK Medical Eligibility Criteria for Contraceptive Use were also available.

Staff had received training for the Mental Capacity Act and how to assess patients' mental capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Nursing staff told us that if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment. They told us that patients had a choice about whether they wished to have a procedure carried out or not. They told us they took the time to fully explain procedures and checked the patient understood them before proceeding.

There was a practice policy for consent to treatment. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes. We were shown an audit that confirmed the consent process for minor surgery had being followed.

Systems were in place to record patients' wishes in relation to 'do not attempt resuscitation'. We saw that care plans were in place and reviewed on a regular basis. However, the patient's capacity to make this decision was not recorded.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. They used the data from QIF and QOF to help to identify these needs.

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history and information about alcohol consumption, smoking and exercise. New patients were not routinely invited for a health screening appointment.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, smoking cessation and referral to the Healthy Lifestyle programme. We were also told that the practice carried out child immunisations and offered family planning advice and support. The nursing team told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They were also proactive in screening patients aged between 18 and 39 years at risk due to their weight. These patients were screened for diabetes and offered lifestyle advice. They had a range of leaflets available to give to patients, and leaflets were also available in the waiting room.

Patient with chronic obstructive pulmonary disease (lung disease) were referred to the pulmonary rehabilitation programme.

Flu vaccination was offered to all over the age of 65, those in at risk groups, pregnant women and children between the ages of two and four. The percentage of eligible patients receiving the flu vaccination was above the national average. The shingles vaccine was offered according to the national guidance for older people.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with the average for the local clinical commissioning group.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from these sources showed patients were satisfied with how they were treated and that this was with care and concern. For example, data from the national patient survey showed that the practice was rated 'in the middle range' for patients who rated the practice as good or very good, with a percentage of 81%. The survey showed that 82% of patients felt that the doctor was good at listening to them, with a score of 76% for the nurses. Both were below the Clinical Commissioning Group (CCG) area average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards which were very positive about the service experienced. Patients said they felt the practice offered an excellent service, and staff were considerate, helpful and caring. One patient commented moving to this practice had restored their faith in doctors, as they felt listened to and never rushed. Another patient commented that treatment was given with dignity and respect and a genuine interest in their wellbeing. We spoke with eight 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. 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 and 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. The practice switchboard was located away from the reception desk which helped to keep patient information private. The seated waiting area was away from the main reception desk, preventing conversations from being overheard. However, we saw that privacy and confidentiality was difficult to maintain at the reception window in the entrance hallway due to the layout of the building. We observed patients queuing to speak with reception staff at the reception window. This area of the building was too small to allow patients at the front of the queue privacy as other patients were stood directly behind them. Reception staff told us they could take patients to a private room if they asked. However, there was no signage to inform patients of this.

Staff told us that the practice cares for patients whose circumstances may make them vulnerable. This included people living in care homes, people with substance misuse and people with a learning disability. Staff told us that these patients were supported to register as either permanent or temporary patients, as the practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

There was information in the practice booklet and on the website stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given the opportunity to ask questions during the consultation. One patient told us they had also been shown information about their condition by medical staff. Patient comments on the comment cards we received were also positive and supported these views. One patient commented that the GPs always listened in a relaxed and unrushed manner, and explained any concerns in detail.

The patient survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice reasonable in these areas. For example, data from the national patient survey showed 66% of practice

respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results. However, both these results were below the average compared to the CCG area.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us that support for people whose first language was not English tended to come from their own family. However, translation services were available.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, long term conditions, those with a learning disability or mental health difficulties, and those requiring end of life care. Individual care plans had been developed for these patients. We reviewed the care plans for a number of patients. We saw that the care plan for a patient with a learning disability included a clear pathway for the patient and carers to follow. The care plan for a patient with chronic lung disease included effective and appropriate care relating to deterioration in condition and best place of care. The plan also demonstrated advice around smoking cessation and the involvement of the Integrated Local Care Team. We saw that multi-disciplinary meetings between GPs, palliative care nurses and district nurses were held monthly to review care plans for patients near the end of their life. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example, coronary heart disease; diabetes; chronic obstructive pulmonary disease (chronic lung disease) and asthma. The Quality and Outcomes Framework (QOF) data that we reviewed showed that the percentage of patients with a mental health diagnosis who had a

comprehensive, agreed care plan documented in the record, in the preceding 12 months was in line with national standards.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 75% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern with a score of 70% for nurses. Both of these were below the Clinical Commissioning Group (CCG) area average. However, the practice survey showed that 77% of patients felt the GP always treated them with care and concern, and 87% of patients for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as excellent.

Leaflets in the patient waiting room and information in the practice booklet and on the website told people how to access a number of support groups and organisations. Staff told us that patients (if they met the criteria) could be referred to a lifestyle coach to assist them physically and emotionally with their condition. The practice's computer system alerted GPs if a patient was also a carer. Information leaflets for carers were available in the waiting room.

Patients nearing the end of their life had their care and support reviewed at monthly multidisciplinary meetings which included practice staff, district and palliative care nurses. One patient who we spoke with told us that the end of life care provided to their relative was 'outstanding'. The practice did not have a set procedure for contacting families who had suffered bereavement. Each GP would decide if contact was required or bereavement counselling should be offered. One GP told us they routinely contacted families who had been bereaved and offered appointments for follow up care. Patients had access to Dove Bereavement Care, a local bereavement counselling service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, appointments were available from 8.30am and through the triage system patients were either seen the same day or given appropriate advice.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. The practice had identified patients most at risk of unplanned admissions and had developed individual care plans for patients. The plans included anticipating the patient's needs and putting measures in place to avoid admission, for example rescue medicines. The practice had reduced the number of admissions for patients with chronic obstructive pulmonary disease (lung disease). They had achieved this by using information from clinical audits and offering lifestyle support and advice to this group of patients.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had signed up to the CCG Quality Improvement Framework (QIF). The QIF shows how improvements have been made across the area, for example in the area of blood pressure control.

The practice had a Patient Participation Group (PPG) and Virtual Patient Group (electronic communication) to help it to engage with a cross section of the practice population and to obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with two representatives of the PPG who explained their role and how they worked with the practice. The representative told us the PPG had a good working relationship with the practice, and the practice listened to their suggestions. As a consequence the practice website had been improved, and the information for patients advertised on the screen in the waiting room.

We spoke with the managers from two local care homes. They told us they worked in partnership with the practice to meet the needs of the patients. The practice visited one care home twice weekly to review patients who required a GP visit. Staff said that between the weekly visits, they could telephone the practice for guidance, or to request a visit. We spoke with staff from a local care home which cared for people with a learning disability. They told us staff were understanding of their needs but also treated them in the same way as any other patient when they visited the practice. They commented that the senior partner and practice nurse carried out the annual reviews in the home.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice provided care and support to house bound patients and patients living in four local care homes. The medical needs of all patients living in the care homes were reviewed at least twice a year. Patients over 75 years of age had a named GP to ensure continuity of care. The practice provided home visits and visited the housebound patients to provide home flu vaccinations to reduce the risk of seasonal infections. The GPs knew the disease prevalence within the practice population and provided services accordingly. For example, clinics for long term conditions such as asthma, diabetes and chronic lung disease.

The majority of the practice population were English speaking patients although the practice could cater for patients who used other different languages through translation services. We saw evidence on the electronic patient record which demonstrated the use of the translation service. Reception staff told us they responded to patient requests for a particular gender or named GP. There were two female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice recognised the challenges presented by the building. Although purpose built, the building was over 30 years old and had limited space in relation to the size of the practice population. The building was two storeys, although patient services were located on the ground floor only. Improvements to the building were included in the practice development plan for 2014–2015. The practice had successfully applied for an improvement grant. The grant would be used to refurbish the sinks in clinical areas and upgrade the nurses' room. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the

Good

Are services responsive to people's needs?

(for example, to feedback?)

treatment and consultation rooms. However, the entrance hallway was too small to provide privacy at the reception window as other patients were stood directly behind them. There were no automatic doors to the building, which made access for wheelchairs users and patients with pushchairs difficult. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. However the toilet facilities did not have a staff call system in place.

Access to the service

The practice booklet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone numbers for the out of hours service were in the practice booklet and on the website.

The practice opened from 8am until 1pm and 2pm until 6pm Monday to Friday. Patients could book appointments at either the main practice or the branch practice. (The branch practice closed at 1pm on a Thursday). The practice operated a morning triage system each week day from 8am, for patients requesting a same day appointment or home visit. The triage nurses contacted the patients to assess their condition, and offer appropriate advice, treatment or appointment. Patients could also request a telephone consultation with the GP where appropriate. The practice did not offer any extended hours. Patients did not raise this as an issue, either when spoken with or through the comment cards.

Patients were satisfied with the appointments system. Patients commented that the triage system worked well. They confirmed that they could see a doctor or nurse on the same day if they needed to. However patients said they may have to wait two to three weeks for pre-bookable appointments with a doctor of their choice. Data from the national GP survey supported this. 79% of respondents stated that they were able to get an appointment last time they tried, but only 57% were able to make an appointment with their preferred GP. Both of these were below the regional CCG average.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice cared for patients who lived in four local care homes. Home visits were made to one local care home on two specific days each week by the named GPs. GPs visited patients in the other care homes as and when requested and also carried out a review of their needs twice a year.

We saw evidence that there was partnership working with other agencies to understand the needs of the most vulnerable in the practice population. This included working with the Integrated Local Care Team (ILCT), a team that included health and social care staff such as community matrons and social workers, to provided coordinated care for patients nearing the end of their life.

Listening and learning from concerns and complaints

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

Patients were made aware of how to complain through the practice booklet, a complaint form available from reception and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions were taken to resolve the complaint as far as possible. The practice had received 19 complaints from December 2013 until 0ctober 2014. We saw that these had been handled satisfactorily and discussed with the relevant member of staff and the wider staff team. Learning from complaints was clearly recorded in the complaints log, and discussed in appraisals and where appropriate, included in a staff member's personal development plan.

The practice reviewed complaints annually to detect themes or trends, and compared complaints year on year. We looked at the report for the last review (2013 -2014) which identified that complaints were now received from a wider range of sources, and over 50% of the complaints related to communication issues.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and annual business plan. The practice vision and values included: to provide holistic and person centred care in a safe environment; to review, improve and innovate our services and care, to develop, train and retain clinicians and staff and to be aware of the characteristics, health and social needs of the communities we serve.

It was clear when speaking with the GPs and the practice staff that they shared this vision and were committed to providing person centred care that met the needs of the practice populations. Patients commented they felt that they received personalised care and support. One patient told us that they were offered advice about support groups to assist them to care for their partner, who had a particular medical condition.

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, or as paper copies. The practice manager told us all policies and procedures were reviewed annually. We saw that this was included in the annual business plan. Staff told us they were informed when a policy needed updating, and review dates were included on the policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and two of the GP partners had lead roles for safeguarding. We spoke with a number 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 held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed that it was performing above national standards by obtaining 99.8 QOF points out a possible 100. The practice had also signed up to the local Clinical Commissioning Group Quality Improvement Framework (QIF). The QIF is underpinned by a learning and development programme, which includes workshops and best practice documents. We saw that QOF/QIF data was regularly discussed at monthly team meetings to identify actions required and remedial action where necessary.

The health care assistant told us about a local Healthcare forum organised by the local Clinical Commissioning Group (CCG), which provided support and clinical updates for practices within the area. They told us that at the last meeting they discussed the care of asthmatic patients and spirometry.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example: infection control, use of non-steroidal anti-inflammatory medicines, falls prevention and chronic obstructive pulmonary disease.

The practice had arrangements for identifying, recording and managing risks. Risk assessments were seen for potential issues such as fire safety and handling of specimens. The legionella risk assessment was still to be completed.

Leadership, openness and transparency

We saw that a range of staff meetings were held, either monthly or quarterly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We looked at the agendas for the different meetings. The meetings were used to discuss a range of topics, including complaints and significant events, as well as ongoing monitoring of performance and updates for the locality meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and whistle-blowing, which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints. The practice was working

Are services well-led?

Good

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

with the Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The 2013 / 2014 patient survey focused on access to and quality of the out of hours service, the repeat prescription services and care provided by the GPs and nurses. The survey did not highlight any issues from patients about the service they received. The PPG representatives told us they would support the practice to link with local initiatives relating to information sharing; developing the practice website and contacting the local area team for NHS England to support the plans for redevelopment of the practice. The results of the survey and action plan were available on the practice website.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). The PPG supported the annual patient survey and two formal meetings had been held during 2013. The practice also utilised the virtual patient group as a means of two way communication to obtain patient views about the service. However the minutes of the meetings were not available on the website or on the notice board in the waiting room for all patients to see.

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

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. Nursing staff told us they could request training that was relevant to the needs of the practice population and the practice supported this. Staff from different teams told us they had an annual appraisal which included a personal development plan.

The practice was able to evidence through discussion with the GPs and staff and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, significant events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant events and complaints had been discussed at a staff meeting held on 22 May 2014. Significant events were also discussed at a team meeting held on 7 August 2014. We saw the practice's significant events log for 2014 which gave details of each incident, who was involved, action taken and lessons learned. We saw that SE's were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust.

The senior partner was responsible for the induction and overseeing of the GP registrar's training. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a GP registrar who told us there was strong leadership within the practice. They told us they felt well supported and secure in their role. They said that they were able to contribute ideas and suggest changes.

A number of the GPs held external and strategic roles with other health agencies. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. The senior partner was a trainer and also involved in the appraisal of GPs as part of their revalidation process. Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council. Another partner had the lead role for information governance within the practice, and was part of the Local Medical Committee (LMC). LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. The salaried GP was a board member of the West Midlands Royal College of General Practitioners (RCGP). The RCGP is the professional membership body for family doctors in the UK and overseas. It is committed to improving patient care, clinical standards and GP training.