Victoria Road Medical Practice

Quality Report

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Date of inspection visit: 15 January 2015
Date of publication: 19/03/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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 Victoria Road Medical Practice on 15 January 2015. We have provided an overall rating of good for this practice. However, there are areas which require improvement in effectiveness, specifically for the population groups where patients were experiencing mental health problems and for patients whose circumstances make them vulnerable. The practice was taken over by the current provider in October 2012 and have recently been working to put plans in place to improve the service which was experiencing difficulties in meeting people's needs. However, they were not able to demonstrate effectiveness in all areas at the time of our inspection.

A medical director was appointed only three months ago to lead and develop the practice. This has resulted in many changes and plans being developed to improve the service overall. As a result, whilst we saw evidence of improvements in all areas, we were unable to assess the effects of some of these after such a short time. We saw that the practice had plans for future developments in all areas but were focusing on establishing robust systems and processes in all areas to facilitate good clinical care.

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

- There was a clear leadership structure and staff felt supported by management.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice were actively seeking feedback from staff and patients and trying to widen the membership of the patient participation group.

Summary of findings

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

- Fully personalise the business continuity plan to ensure it contains all details specific to the practice.
- Introduce systems to ensure that staff are up to date with mandatory training such as fire and Mental Capacity Act (2005) training.
- Provide more comprehensive information regarding methods of booking appointments, out of hours arrangements and the complaints procedure to patients in the practice leaflet.
- Introduce more robust methods to ensure that difficult cases and review of elective and urgent referrals are formally discussed and documented to facilitate learning and ensure all staff delivering care are aware of any changes.
- Progress the establishment of multi-disciplinary meetings for palliative and end of life care and patients with complex conditions.
- Continue to develop and establish robust systematic processes to manage patients' care from vulnerable groups and those with mental health problems.
- Ensure that a policy is developed to ensure consistency in medication reviews and the coding.
- Ensure that the legionella testing is completed as soon as possible and a more robust system for future checking is introduced.

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 has been 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 but significant event reporting and sharing of analysis was only evident over the last few months therefore we were unable to demonstrate a safe track record over time. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed but the practice should develop a more robust system for reporting risks and demonstrating on a daily basis additional risks identified and how they have mitigated them. There were enough staff to keep patients safe. The practice demonstrated that they were in the process of developing systems further and it is anticipated that these will be adopted and effective over time.

Are services effective?

Requires improvement

The practice has been rated as requires improvement at this time for providing effective services. The data available to us showed patient outcomes were below the average for the locality. This was due to the provider taking over the practice at a time when patient care and data had been not been optimum in areas such as mental health and for patients in vulnerable circumstances, due to organisational changeover issues and indicated immediate improvements were required. Since acquiring the practice the provider have taken actions and implemented systems and processes to improve patient care. However, the effectiveness of this can only be assessed after a period of time. Therefore, for population groups where patients were experiencing mental health problems and those whose circumstance made them vulnerable, effectiveness could not be evidenced at the time of inspection.

We found that staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient'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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Multidisciplinary team working was in the process of being implemented and had not yet been established.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. We were able to obtain sufficient information to determine that the practice was caring. Patients told us 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. Patients said they found it easy to make an appointment with a GP with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available in the surgery although not in the patient leaflet at the time of inspection. Learning from complaints with staff and other stakeholders took place.

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 being established but in its infancy. 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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and opportunistic treatments when appropriate.

People with long term conditions

Good

The practice has been 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. Since the appointment of more qualified suitably skilled staff, we saw that processes were being implemented to manage long term conditions effectively.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice has been rated as good overall for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability and offered longer appointments for those patients.

The practice 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.

They were starting to establish links with the multi-disciplinary teams in the case management of vulnerable people but this was in its early stages and had not yet become established and there were currently no written protocols regarding end of life or palliative care.

People experiencing poor mental health (including people with dementia)

Good

The practice has been rated as good overall for the care of people experiencing poor mental health (including people with dementia. They were working towards offering people experiencing poor mental health an annual physical health check but this was opportunistic and no systematic process was in place. The practice was in the early stages of implementing meetings with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They were also starting to complete advance care plans for patients with dementia and had committed to the enhanced service for dementia care. However, we could not evidence that this was established and effective at the time of our inspection.

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 (A&E) where they may have been experiencing poor mental health. Staff had had not yet accessed training in the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

Patients we spoke to 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.

We received 15 comment cards. Most of these commented that they were happy with the care they received. Patients commented that they did not feel rushed during consultation and commented on the caring and polite reception staff. There were also comments that patients had noticed improvements in the practice recently and generally they were able to access an appointment without difficulty.

Areas for improvement

Action the service SHOULD take to improve

- Fully personalise the business continuity plan to ensure it contains all details specific to the practice.
- Introduce systems to ensure that staff are up to date with mandatory training such as fire and MCA training.
- Provide more comprehensive information regarding methods of booking appointments, out of hours arrangements and the complaints procedure to patients in the practice leaflet.
- Introduce more robust methods to ensure that difficult cases and review of elective and urgent referrals are formally discussed and documented to facilitate learning and ensure all staff delivering care are aware of any changes.
- Progress the establishment of multi-disciplinary meetings for palliative and end of life care and patients with complex conditions.
- Continue to develop and establish robust systematic processes to manage patients' care from vulnerable groups and those with mental health problems.
- Ensure that a policy is developed to ensure consistency in medication reviews and the coding.
- Ensure that the legionella testing is completed as soon as possible and a more robust system for future checking is introduced.

Victoria Road Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and another CQC inspector.

Background to Victoria Road Medical Practice

Victoria Road Medical Practice provides a range of primary medical services to a population of approximately 5,800 patients in the Bedford centre, Kempston, Elstow, and Shortown area. The practice population is predominantly Asian but also includes patients from ethnic minority groups such as those originating from Eastern Europe and Asia. It serves a significantly higher than average number of people in the age groups of 0-10years and 25-39 years.

The practice has undergone an ownership change in October 2012 and delivers services under an alternative provider medical services contract (APMS) from Phoenix Primary Care Limited. They have been working since that time to put systems and processes in place, increase and establish a stable workforce, and develop services and improve outcomes for patients. The practice have an additional contract which requires them to provide appointments for patients who attend A&E and who are redirected if their care is deemed appropriate to be delivered at a GP surgery.

The practice employs three GPs, two females, one of whom is the medical director and one male GP. There are two advanced nurse practitioners, a practice nurse, a health care assistant and a practice manager who is supported by a number of reception and administrative staff.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place. The latest data available to us prior to inspection showed some areas of higher than average risk relating to conditions such as diabetes, mental health and chronic obstructive pulmonary disease.

Out of hours care when the surgery was closed was accessed via the NHS 111 service.

Why we carried out this inspection

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

We carried out 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

Detailed findings

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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with NHS England and the local clinical commissioning group and a member of the patient participation group.

We carried out an announced visit on 15 January 2015. During our visit we spoke with a range of staff. We spoke with the GP medical director, another GP, an advanced nurse practitioner, the practice manager, members of the reception staff and with patients who used the service. We observed how patients and family members were dealt with by staff during their visit to the practice.

Good

Are services safe?

Our findings

Safe track record

The practice had a appointed a medical director in November 2014 who had responsibility for ensuring that systems and processes for ensuring safety were in place and maintained and managing risk. The practice used a range of information to identify risks and improve patient safety. For example, the practice had a system where reported incidents are dealt with immediately if necessary and taken to a clinical meeting to ensure shared learning. National patient safety alerts were acknowledged and discussed at clinical meetings if relevant. Comments and complaints received from patients were also shared with staff at regular meetings. We saw evidence from minutes of meetings to confirm this.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there was discussion at clinical meeting where a clinical diagnosis had been made in A&E which should have been found and dealt with by the practice. There was evidence of discussion regarding how this could be avoided.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had begun to establish a safe track record which they could build upon with the systems and processes now in place to maintain it.

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 year and we were able to review these. Significant events was a standing item on the practice meeting agenda and we saw minutes of meetings to confirm this. There was evidence that the practice had learned from significant events 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 to report incidents to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result where medication had been prescribed inappropriately due to the use of both generic and brand names of medicines. We saw that the practice had directed that all prescribers used generic names in future to eliminate the risk of this happening again. However, it was noted that there had only been five incidents reported over the last year. We noted that three of these had been since the appointment of the medical director which indicated that the process was starting to become embedded in practice.

National patient safety alerts were disseminated by the practice manager to practice staff and discussed at practice meetings if relevant. 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 if necessary 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 vulnerable children, young people and adults. We saw pathways for dealing with children that did not attend appointments at hospital and the GP surgery which was clear and robust and included liaison with other services such as the multi-agency agency safeguarding hub (MASH) and social services. The practice had appointed two dedicated GPs for safeguarding, one for children and the other to lead safeguarding vulnerable adults. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We saw that clinical staff had been trained in safeguarding children level 2 and 3 and non-clinical staff in level 1. We asked members of medical, nursing and administrative staff about their most recent training and 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 within the safeguarding policies and all staff had online access to these.

We saw that 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, a child subject to child protection plans, patients with caring responsibilities and those with carers. The practise also had a system for identifying children who had missed two appointments whereby they would contact the parents and advice of further action with regards to information sharing with local authority staff /health visitors if a third was missed. The system also highlighted patients who had been recently bereaved and may have required additional support.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Records were kept on an electronic system called SystmOne which collated all communications about the patient including scanned copies of communications from hospitals the Out of Hours service and NHS 111. The practise was planning to commence an audit of this process to ensure accuracy and safety.

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. Discussions with staff confirmed that they followed the policy. We saw records that showed that the fridge temperature was checked daily and staff were able to describe the actions they would take in the event of a failure.

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.

Vaccines were administered by members of the nursing staff. The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that the nurses had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and had received regular supervision and support in the role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Reception staff had received training in the management of the repeat prescriptions. There were systems in place to ensure that the patient's repeat prescription was still necessary and appropriate.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place outlining daily, weekly and quarterly tasks and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. They commented that they had observed staff using disposable gloves and hand washing as required.

The practice had an identified lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out two audits in the last year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

We saw that 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. There was also a policy for needle stick injury, and flow charts within the treatment rooms advising staff of the procedure to take should such an injury occur.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). However we did not see any evidence that regular checks were being carried out in line with this policy to reduce the risk of legionella. During the inspection the practice advised us that an assessment of the building to include legionella check will be arranged and they agreed to put in place the necessary checks. A risk assessment in the form of a compliance log had identified that an infection control audit was required which should have identified the legionella check but this had not been noted prior to our inspection.

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 of September 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example, weighing scales and the fridge thermometer. All equipment had been calibrated in June 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were informed that references were kept centrally with Phoenix Primary Care which was in line with the recruitment policy. The practice had an appropriate recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Only one member from each staff group was allowed leave at a time. Locum GPs were used to cover any GP absence of more than three days.

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 informed us that the surgery has a full complement of staff at this time. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. 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.

The practice had identified and mitigated risks that were included on a compliance log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared that a lead for infection control was needed and this had been actioned.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. A member of reception staff told us how they would manage a patient whose condition deteriorated whilst in the waiting room, the actions they would take and who they would call for support.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records that showed all staff had received training in basic life support. Emergency

Good

Are services safe?

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. The minutes of the practice meetings confirmed that staff had discussed significant events.

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, breathing difficulties and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to, but there were some areas which required personalisation for the premises and provider.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that all staff with the exception of two, were up to date with fire training. The practice manager told us that one member of the staff was new and the other had been on maternity leave. They informed us that this would be arranged imminently. There were no records of fire drills taking place but the practice manager told us this was planned for the coming year.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed. The GPs had also attended a GP update session on updated NICE guidance. 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 and advanced nurse practitioner told us there was a lead in specialist clinical areas such as heart disease, mental health and stroke and there was specific administrative staff allocated to each area to support this work. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We saw that the advanced nurse practitioner had carried out a clinical audit in chronic obstructive pulmonary disease (COPD) and which identified patients with potential undiagnosed COPD. As a result these plans were made to invite patients for screening to identify any patients who had not been diagnosed.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was the lowest compared to other practices in the CCG cluster. One GP had completed an audit of the records of patients with high blood pressure to ensure that the register was accurate and patients were receiving the best clinical management of their condition.

The GPs told us that they had verbal discussions between colleagues regarding difficult cases and review of elective and urgent referrals which were made but this was not documented. This practice should document this to ensure that any changes can be seen by all clinicians providing care and also lessons can be learnt. The medical director told us that all referrals made by locum GPs were reviewed by them before being sent. They had an interest in mental health and dermatology and referrals in those conditions were sent in house to them to determine further action or treatment necessary. The practice demonstrated that they were planning and starting to try to establish systems to communicate and share information regarding patient care but this is work in progress and there was no evidence of its effectiveness at the time of our inspection.

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 patient's age, gender, race and culture as appropriate. We saw evidence of training in equality, diversity and human rights in the last year.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, each GP and advanced nursed practitioner were responsible for an area of chronic disease and QOF domain. We saw a schedule clearly outlining which area each clinician was responsible for and the administrative support staff allocated to them. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. We saw audits carried out by GPs and ANPs involved in their allocated area of work. For example, the ANP had carried out an audit in COPD.

The practice showed us three clinical audits that had been undertaken in the last three months since the appointment of the clinical director. As the audits were so recent none of the audit cycles were complete, but all had the first cycle completed with a review date for 2015. However, the audits carried out were relevant and we saw evidence of a change and improvement of treatment to patients as a result. For example, patients had been identified, contacted and medication reviews were carried out to change their medication as a result of the audit. We saw evidence of one completed audit in 2013 regarding review of patients using inhalers. We saw that this had also resulted in a change of treatment for patients.

The practice had identified future clinical audits to be carried out in 2015. They showed us a summary of the next three clinical audits which were planned. These included

Requires improvement

Are services effective?

(for example, treatment is effective)

asthma, dementia and mental health. GPs we spoke with told us that results from audit were shared at clinical meetings and we saw confirmation of this in the audit summary.

The GPs told us clinical audits were often linked to medicines management information, or as a result of information from the quality and outcomes framework (QOF). (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). For example, we saw an audit regarding seeking out patients who may have had undiagnosed COPD. Discussions with GPs and the ANP demonstrated a commitment to continuing the audit process and changing practice as a result.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had been taken over in October 2012 and the new providers were aware of the lower than the CCG and national achievement in several areas of QOF and were taking actions to address this specifically in COPD, asthma and diabetes and mental health.

Discussions with the ANP demonstrated a plan to increase all QOF clinical areas by more consistent and robust systems, including audit, call and recall. We saw from the clinical systems that they had already increased achievement for this year and anticipated an overall achievement of approximately 90% at the end of March 2015 and we saw that they had a 10% higher achievement at the time of our inspection compared with the same time last year.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement. However, we did not see evidence that all GPs were participating in audit. The medical director confirmed that this is an area they intended to address to ensure that everyone becomes involved and undertakes audit.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. However, the practice did not have a policy on medication review and discussions with clinicians revealed that not all clinicians used the same coding on the computer to enable consistency of recording. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice had an identified lead for prescribing who attended prescribing meetings run by the CCG cluster where best practice was shared. Information from this meeting was shared at the practice clinical meetings and we saw minutes to confirm this.

The practice had a palliative care register. They had plans to implement the gold standards framework for end of life care and we saw that a multi-disciplinary meeting had been scheduled for later in January 2015 to facilitate a collaborative approach to care and ensure the needs of palliative care patients were being met. The practice told us that this was part of the practice plan, which was to develop areas where gaps in care had been identified. It was planned that MacMillan nurse, health visitor and mental health nurse would be involved in these meetings and we saw a list of staff who had been invited to confirm this. However, at the time of our inspection this had not taken place, therefore we were not able to assess the success or effectiveness or this, but was anticipated it would be initiated and continue to become embedded in practice over the months to come.

Whilst the practice were able to demonstrate they were addressing some areas of chronic disease and putting in plans and resources to achieve better outcomes for patients, it was noted that evidence of the outcomes could not be seen at the time of inspection.

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. There were sufficient doctors with additional skills in areas such as dermatology and mental health. One GP was sourcing additional training to insert hormonal implants for

Requires improvement

Are services effective?

(for example, treatment is effective)

contraception in the near future. One ANP had additional training in asthma and COPD and told us that they were continuing professional development undertaking a masters degree in a health related subject.

The GPs we spoke with were up to date with their continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Practice nurse and health care assistant appraisals were carried out by the ANP and the medical director carried out appraisals for ANPs. GPs received annual in-house appraisals in addition to their CCG appraisal. We spoke with a selection of clinical and administrative staff who felt there was a good skill mix and expressed that they were supported in their role to develop. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. All staff had access to online training and attended the health education and training sessions organised by the clinical commissioning group .

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. The ANP had additional training and knowledge of long term conditions such asthma and COPD.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 NHS 111 service both electronically and by post. The practice told us that any abnormal results would be faxed or telephoned. They 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. Staff we spoke with confirmed that they were aware of this process. The GP on call saw these documents and results and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had committed to participate in all directed enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). They were calling patients to the surgery to develop and discuss care plans.

They had a process in place to follow up patients discharged from hospital and review patients who had attended A&E and the out of hours service. Reception staff told us that they received the notifications and they were transferred to the appropriate GP.

We saw that the practice had planned to hold the first multidisciplinary team meetings later in January 2015 to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. The practice told us that up to this time they had discussed these patients in their own clinical meetings but had not involved the multidisciplinary team. They had acknowledged that this was an area for development and required improvement and had started to address it

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice used the Choose and Book system. (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). Staff reported that this system was easy to use. The GPs showed us that a leaflet is provided to patients when using this service. We saw that there was an information sharing policy in place for all staff to refer to.

The practice has signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had a letter template in use for emergency admission and A&E attendances which they completed and sent to the appropriate area. GPs we spoke with told us that if a patient required admission following a home visit then a summary record was sent with the patient.

The practice had systems to provide staff with the information they needed. Since June 2013 the practice staff have used an electronic patient record called SystmOne to coordinate, document and manage patients' care records. All staff we spoke with 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

We spoke with staff who demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. Clinical staff we spoke with demonstrated an general understanding of the key parts of the legislation, however, no staff had undertaken MCA training at the practice.

The practice had appointed a lead GP for patients with dementia and a lead GP for those patients with learning disabilities. Patients 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 with the patient and their carer. All clinical staff we spoke with demonstrated a clear understanding of Gillick competency. (Gillick competence refers to a child under 16 who is able to demonstrate they have legal capacity to make decisions and give consent to care and treatment without parental consultation).

The practice showed us that all consent was recorded electronically on a specific template in the clinical system. There was a practice policy for documenting consent for specific interventions, although they did not offer minor surgery or joint/soft tissues injections. Patients we spoke with told us that the practice always sought consent before carrying out any procedure.

Health promotion and prevention

Staff we spoke with told us that the practice offer a health check with the health care assistant 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. Patients were offered smoking cessation support when appropriate and staff told us that they referred to level three service if more intensive support is required to help patients through a smoking cessation programme. We saw evidence that the practice had already achieved a high level of patients whose status had been sought and had been offered smoking cessation support or referral.

We saw evidence that the practice offered physical and mental health support which were in the main associated with the QOF and enhanced services. For example, the practice offered chlamydia screening as part of a local enhanced service and we saw that they also offered lifestyle advice.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up and we saw that they had a clear pathway in place for dealing with patients at risk of cardio vascular disease.

The practice kept a register of all patients with a learning disability which showed there were 19 patients who had been offered an annual physical health check last year and these were to be carried out again prior to March 2015. The practice had a high achievement in smoking status and we saw records that showed they identified the smoking status of 94.4% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

The practice's performance for cervical smear uptake was 75% and the GP told us that they had one dedicated nurse and two GPs involved in providing the service. The practice had planned to actively contact patients who did not attend for cervical screening. We saw that they had been actively making plans to address poor uptake and were exploring ways of obtaining information in different languages to make patients more aware of the procedure and what it entailed. They told us they intended to advertise the importance and benefits of cervical screening more widely.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all primary immunisations in children aged12 months was above average for the CCG and the practice had a clear policy for following up non-attenders by the named practice nurse.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice offered shingles vaccines to those patients who were eligible and we saw that they had completed 43 at the time of our inspection. The practice also confirmed that all housebound patients had been visited and had received their flu vaccination.

There was a register kept of patients who were identified as being at high risk of admission. The practice were in the process of calling patients to the surgery and developing care plans and this was progressing but not yet complete. All patients over 75 had a named GP. At the time of inspection the practice had not established multi-disciplinary meeting but we saw that this was scheduled to start in January 2015 along with joint end of life care plans.

The practice had been working to standardise their approach to long term conditions and address areas of concern. We saw that they had reviewed disease registers and addressed incorrect coding issues. They had adapted templates to ensure that all contacts with patients were used effectively allowing opportunistic health advice, promotion and treatment. We saw they had made changes to alert staff regarding what patients required review and what was required at that review to prevent anything being omitted.

The ANP held joint clinics with the practice nurse and liaised with the integrated community diabetes service team when necessary. We saw that work had taken place to identify patients with undiagnosed COPD and that all disease registers were being reviewed and monitored. Discussions with the ANP demonstrated that they had been planning and working to improve all areas of chronic disease. They reported that they now had a full complement of staff and a clear plan to address chronic disease management and were already starting to improve. However, they acknowledged that this will take time to complete.

The practice held offered child health medical with the doctor at eight weeks of age at the time of the first immunisation. The midwife attended the practice on two mornings a week to support women during pregnancy.

The practice had committed to participate in the dementia enhanced service and had allocated a lead GP for dementia. Work was on-going in this area and the practice told us that they were liaising with the community mental health teams and had plans for them to attend the multi-disciplinary meetings when they became established.

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. The evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example 76% of patients reported the GPs were good at listening to them but only 68% of respondents said the last GP they saw or spoke to was good at giving them enough time which was below the CCG average of 87%. The practice acknowledged that it had not had a regular team of doctors until very recently, but now they have a more stable team they are hopeful this will improve. The patient survey reported that 96% of patients felt the last nurse they saw was good at listening to them which was above the CCG average of 84%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 15 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Only two comments were less positive regarding the wait for an appointment. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Some of these patients commented that they did not always get to see the same GP if they required and emergency same day appointment and one commented that they were usually given an appointment with an Advanced Nurse Practitioner (ANP) rather than a GP. They expressed a preference that they would prefer to see a GP. The practice had their own comments book in reception for patients to provide feedback which contained 12 positive comments made in the past four months.

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. The reception desk and was shielded by glass partitions which helped keep patient information private. There was a private room at the back of the reception area that could be used for any patients wishing to discuss matters of a confidential nature and a notice in the waiting area to inform patients of this. There was also an electronic checking in system available in six languages for patients to use to reduce the amount of patients at the reception area.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded fairly 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 68% of practice respondents said the GP involved them in care decisions and 71% felt the GP was good at explaining treatment and results.

Patients we spoke to 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 the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language they told us that patients requiring a translator were given a 20 minute appointment. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The patients we spoke with on the day of our inspection and the comment cards we received suggested that the practice staff supported patients with their care and treatment.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. There was a wide range of health promotion information in the waiting room including seasonal advice regarding flu and also self-help guidance for smoking cessation and support groups for alcohol abuse. There was also information about childhood immunisations and eye tests for children, advice on long-term conditions such as diabetes.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them by letter. We saw a copy of the standard letter in use offering support at the surgery if required and also providing information regarding bereavement support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had recently introduced new management and we saw evidence that they had been responsive to patient's needs and taken steps to address any areas they considered were falling short. We saw that the needs of the practice population had been understood and systems were being put in place to address identified needs in the way services were delivered. For example, there had been no patient participation group at the practice and that had been addressed and was in its developmental stages. The practice had noted that patients were not experiencing a systematic approach to their chronic disease and had started to implement changes in how they manage long term conditions. They had employed appropriate staff with skills which could impact on these areas and improve outcomes for patients.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged 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.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example people whose first language was not English, patients with learning disabilities and parents with young children.

The practice had access to translation services through the local authority. They also had reception staff who spoke a variety of languages such as Italian, Punjabi, Hindu and Polish to assist patients.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and we saw the training matrix which confirmed this had been undertaken.

The premises and services had been adapted to meet the needs of patient with disabilities. There were electronic doors to the entrance of the building and a lift was available to transport patients with mobility problems if they needed to access treatment on the first floor. We noted however, that most consultations took place on the ground floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a high number of speaking patients though it could cater for other different languages through translation services.

Access to the service

Appointments were available from 8.30am to 6.30 pm on weekdays and the practice opened on Saturday morning from 9am to 12 midday for booked appointments only to provide access for those people who work or could not attend the surgery during normal hours. This was particularly useful for patients who worked during the week and children and young families. We saw that appointments were bookable up to eight weeks in advance.

Information was available to patients about appointments in the practice leaflet although there was no reference to out of hours provision or the availability of online appointments or prescriptions. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. We noted that the practice website was not up to date with accurate information about the practice. The medical director told us that there were already imminent plans in place to update this and meetings were taking place that week to initiate this.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made by the GP when requested to local care homes but the practice had a significantly lower than average number of older patients therefore they did not make routine visits to care homes. The practice told us this was an area where they were considering development. For example, to plan regular routine visits and carry out reviews.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to although it may not always be a doctor of their choice. They told us they could see another doctor if there was a wait to see the doctor of their choice. The practice also provided a service under a separate contract where all patients in the area who had attended A&E and who could be dealt with by a GP were referred back from A&E to be treated at the practice. The practice reported that this service was not well utilised.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled complaints and took appropriate action. We looked at four complaints received in the last 12 months and found that these were satisfactorily handled. They had been dealt with in a timely way with openness and transparency. We noted that the complaints left on NHS Choices were not logged in the complaints file although they had been responded to.

We saw that there was a poster was in the waiting room to help patients understand the complaints system, however, there was no reference to information regarding the complaints procedure in the practice leaflet or on the website, although the practice told us that the website was currently being reviewed and updated. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw that complaints were discussed at practice meetings and a summary of complaints was available with actions and lessons learned. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 undergone a change in management in recent months and a new medical director had been appointed to lead the practice. The practice acknowledged that it would take time to implement changes but a clear vision to deliver high quality care that was holistic and responsive to patients' needs and preferences and promote good outcomes was demonstrated. The practice provided details of the vision and practice values which were part of the their strategy and business plan.

To achieve their vision the practice told us they had committed to recruiting an increased workforce with the right behaviour and attitudes. We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All staff we spoke with expressed enthusiasm and a commitment to the values of the practice and had welcomed the change in leadership.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. They were also available in hard copy and we looked at a selection of these policies and procedures, for example needle stick injury, infection control, whistleblowing. There was a member of staff responsible for ensuring that all staff had seen and read the policies. The policies we saw had been reviewed within an appropriate timescale.

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 a named lead GP for prescribing. Staff we spoke with 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. The QOF rewards practices for the provision of 'quality' care and helps fund improvements in the provision of clinical care. The QOF data for this practice showed it was performing below the CCG and national standards in several areas. The practice told us that lower than average QOF achievement had been evident for two years and this was a major priority and was currently being addressed . The practice had identified leads for all QOF areas to ensure ownership that a systematic approach was introduced and registers were reviewed and accurate. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. We saw evidence of an action plan to address some of these areas that had been discussed with the CCG and NHS England.

The practice had developed an ongoing programme of clinical audits which it intended for use to monitor quality and systems to identify where action should be taken. For example, there was a plan to carry out an audit of the mental health register and the dementia register to establish if patients were diagnosed and treated appropriately and determine whether care plans were being monitored appropriately.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their system for managing risk, which addressed a wide range of potential issues such as staffing and infection control. We saw that the risk log was in the form of an annual compliance log which although it had identified risk at a specific time, did not enable new risks to be identified as they arose as it was an annual summary. There was not a system in place to identify risks on a regular basis and assure themselves that new risks have been mitigated as and when they arise. We saw from the compliance document that risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example identification of an infection control lead and implementation of an infection control audit.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, approximately every six weeks in addition to the clinical meeting. All staff were invited to attend. The non-clinical staff told us they attended and cascaded information to colleagues who were not able to attend.

Are services well-led?

Good

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

Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings. Minutes from meetings and discussions with staff confirmed this.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff such as whistleblowing, safety and security and sickness & absence policy. We looked at the staff paper copies of the handbook but these were also available to staff electronically. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the patient survey and we saw that they had placed a comments book in the waiting room. They had a patient participation group (PPG) which formed in September 2014, as they had experienced difficulty in getting patients to commit to this group. However, the practice PPG had now formed and consisted of a representative from different ethnic groups and ages, although the practice told us they had agreed to try to attract more younger members to join the group by the use of SMS text messaging and social media.

We spoke with a representative of the PPG who expressed that they felt the practice had improved. They told us that they found the appointments were more streamlined and the waiting room more organised and less busy. They told us that only two meetings had taken place to date. We saw that the practice had already agreed to support them in issues around parking. We saw from the meeting minutes that the PPG was attended by representatives from the practice staff as well as patients but noted that only one patient member had attended the second meeting. The practice should continue to try explore different ways to encourage a larger membership of the PPG.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and 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 and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and the advanced nurse practitioner told us that one of the GPs acted as a mentor for additional degree level training they were undertaking. Staff reported that they felt all areas of the practice had improved in the last few months and that leadership and management had improved considerably. The medical director had only been in post for three months. However, from the evidence and plans seen and discussions with the medical director and staff, it is expected that this leadership will continue and drive improvements in all areas which should be evident in six months to a year.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings . We noted that there had only been four significant events recorded over the last 12 months. It was acknowledged that the medical director had only been appointed in November 2014 since which time three of the incidents had been reported which indicated that this was being embedded in practice.