Hartshill Medical Centre

Quality Report

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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 24 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in all five of the domains. We found the practice provided good care to older people, people with long term conditions, people whose circumstances may make them vulnerable, families, children and young people, working age people 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.
- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make required improvements to the practice when required.
- Patients were satisfied with how they were treated and this was with compassion, dignity and respect. GPs were good at listening to patients and gave them enough time.
- Most patients told us they were satisfied with the appointments system and that it met their needs.

We saw several areas of outstanding practice including:

- The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided care for. To do this, carers were offered additional health checks and the 'flu vaccination.
- The practice kept daily open appointments so if one of their patients inappropriately attended the neighbouring A&E department, they could be re-directed back to the practice to ensure they received the most appropriate care and treatment.
- The practice ran an annual health promotion event aimed mainly at patients from black minority groups who were at a higher risk of diabetes and

Summary of findings

cardiovascular disease. These were held in the evening to allow working age patients to access them. The practice had identified several patients with undiagnosed diabetes as a result of the events.

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

The provider should:

- Provide staff with training in safeguarding vulnerable adults at a level appropriate to their role.
- Carry out safeguarding checks to ensure that receptionists who carry out chaperoning duties are suitable to work in this capacity.
- Develop a long term business plan that encompasses a risk management structure to ensure systems that are in place will be maintained when experienced staff leave and take their knowledge and experience with them.
- Complete clinical audit cycles to monitor that changes made to patients' care and treatment have made improvements to their health outcomes.
- Introduce a systematic way of reviewing and evaluating which NICE guidelines are appropriate to meet their patients' needs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have 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. Data showed that patients rated the practice higher than other practices in the region for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

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

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients near the end of their life and those with a learning disability. It had carried out annual health checks for people with a learning disability and provided support and care to carers of vulnerable people through health reviews and providing 'flu vaccinations. It offered longer appointments for people with a learning disability.

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). One-hundred per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and Healthy Minds. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have experienced poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

All of the four patients we spoke with on the day of our inspection were very complimentary about the care and treatment they received. We reviewed the 31 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were overwhelmingly positive. Patients told us the staff were always helpful, understanding, professional, very caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Most patients told us the appointment system was easy to use and met their needs.

The results from the National Patient Survey showed that 94% of patients said that their overall experience of the practice was good or very good and that 86% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

Provide staff with training in safeguarding vulnerable adults at a level appropriate to their role.

Carry out safeguarding checks to ensure that receptionists who carry out chaperoning duties are suitable to work in this capacity.

Develop a long term business plan that encompasses a risk management structure to ensure that systems that are in place will be maintained when experienced staff leave and take their knowledge and experience with them.

Complete clinical audit cycles to ensure that changes made to patients' care and treatment have made improvements to their health outcomes.

Introduce a systematic way of reviewing and evaluating which NICE guidelines are appropriate to meet their patients' needs.

Outstanding practice

The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided care for. To do this, carers were offered additional health checks and the 'flu vaccination.

The practice kept daily open appointments so that if one of their patients inappropriately attended the neighbouring A&E department, they could be re-directed back to the practice to ensure they received the most appropriate care and treatment.

The practice ran an annual health promotion event aimed mainly at patients from black minority groups who were at a higher risk of diabetes and cardiovascular disease. These were held in the evening to allow working aged patients to access them. The practice had identified several patients with undiagnosed diabetes as a result of the events.

Hartshill Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Hartshill Medical Centre

Hartshill Medical Centre is a purpose built, primary care medical centre. The building was completed in December 2012 and serves the local population by providing general practitioner services. All clinical rooms, treatment rooms and utility rooms are located on the ground floor. There is a fully equipped theatre at the practice where GPs carry out minor operations such as vasectomies.

A team of four GP partners, one salaried GP, five nurses, a practice manager, five receptionists, a counsellor and two administrative staff provide care and treatment for approximately 6500 patients. There are four male GPs and one female GP at the practice to provide patients with a choice of who to see. The practice is a training practice for medical students and GP registrars to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

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

Before carrying out our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a spokesperson from the Patient Participation Group (PPG) and representatives from two care homes where Hartshill Medical Centre provided care and treatment to several of their patients. We carried out an announced visit on 24 November 2014. During our inspection we spoke with two GPs, one GP registrar, two nurses, two receptionists, the practice manager, one member of the administrative staff and four patients. We observed how patients were cared for. We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report significant events and near misses. For example, one member of staff described how they reported a significant event after a patient who had been prescribed a travel vaccine had stored it in their home fridge. This meant that the temperature range the vaccine had been stored in had not been monitored to ensure it was stored safely in line with the manufacturers' guidelines. The member of staff described to us the learning the practice had gained from this significant event and the systems that had been put in place to prevent this from occurring again.

We reviewed the practices' annual audits of significant events. These demonstrated that the practice had managed these consistently over time and so showed 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. We saw records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standard item on the GP partners' and nurses' meeting agendas and a dedicated meeting was regularly held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Although the receptionists and administrative team did not have regular formal meetings, there was a system in place of sharing lessons learnt from significant events with them. Reception staff we spoke with were able to describe this system to us and gave examples of changes made as a result of a significant event. For example, following an incident where a patient had not received their prescription, a book had been introduced for pharmacists to sign to document they had collected a prescription for a patient. This enabled an audit trail of when prescriptions were collected by a pharmacist for a patient.

Staff completed significant event forms on the practice's computer system and sent completed forms to the practice manager. The practice manager showed us the system they used 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, after a patient had stored a travel vaccination in their home fridge, the practice purchased a small stock of this vaccine so that it was readily available at the practice. In addition to this, an advisory note was printed on all relevant prescriptions instructing the pharmacist that the vaccine must be delivered directly to the practice.

We saw a safety alert protocol at the practice that outlined how national patient safety alerts, such as alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), were disseminated. We saw that alerts were viewed by a designated person then cascaded to the appropriate staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they provided. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any action staff needed to take.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that most staff had received safeguarding children training at a level appropriate to their role. Whilst most staff had received training in safeguarding vulnerable adults, clinical staff had not received the higher level two training that is applicable to their role. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, accurately record documentation of safeguarding concerns and how to contact the relevant agencies in and out of normal hours. Contact details were easily accessible and displayed in the treatment and consultation rooms.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had received the higher level three safeguarding training to fulfil this role. All the staff we spoke with were aware who the lead was and who to speak to in

the practice if they had a safeguarding concern. The practice met every eight weeks with a member of the Health Visiting team to discuss any concerns they may have regarding children at the practice. We spoke with the named Health Visitor for the practice prior to our inspection and they told us that they had a good working relationship with the practice that included the sharing of information and concerns.

An up to date chaperone policy was in place at the practice. Posters were displayed in the treatment and consulting rooms informing patients of their right to have a chaperone present during a sensitive examination. Chaperone training had been undertaken by all the nursing staff. If a member of the nursing staff was not available to act as a chaperone some receptionists had undertaken training. Staff we spoke with understood their responsibilities when acting as chaperones which included where to stand to observe the examination and what to do if they had any concerns regarding the examination.

Checks to ensure that had clinical staff were suitable to work with patients had been carried out. A risk assessment flow chart had been used to identify that administrative staff such as receptionists, did not require safeguarding checks to be completed. However, the flow chart did not recognise the increased risk to patients if a receptionist carried out chaperoning duties and had not been subject to safeguarding checks.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, System One, which collated all communications about the patient including scanned copies of communications from hospitals and results from tests and X-rays.

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. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they cared for. To do this, carers were offered additional health checks and the 'flu vaccination.

Medicines management

We checked the medicines stored in the designated medicine room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. A log of the fridge's temperature ranges had been recorded daily which demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Medicines were administered safely. We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. All the PGDs were in date except one which the practice was aware of and were in the process of updating it. A risk assessment had been carried out to ensure it was safe for nurses to continue to administer the vaccine.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms used by GPs on home visits were handled in accordance with national guidance. They were stored in a locked cupboard and the serial numbers of prescriptions pads were recorded to prevent access to medicines in the event of theft of the GPs' prescription pads.

Good

Are services safe?

Cleanliness and infection control

We observed the premises were visibly clean and tidy. We saw there were cleaning schedules in place 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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. 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 regular infection control audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. We saw that both single use items were used for minor surgery alongside sterilised instrument packs for more complicated surgery such as vasectomies. There was a system in place for ensuring the packs were in date and we saw that they were. There was a policy for needle stick injuries and staff knew what to do if this occurred. 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.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in September 2014 to protect patients and staff from harm. Staff described to us the actions they took to prevent the growth of the legionella virus.

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 such as weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and safeguarding checks. The practice had a 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. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice had a low turnover of staff but when a member of staff had left, they had received an exit interview. This had been carried out to identify their reasons for leaving and to help the practice to review any changes that may be needed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw there was a building inspection and maintenance programme in place which included annual or monthly checks of the building including emergency lighting, fire alarm testing and fire extinguisher and gas safety checks. The practice also had a health and safety policy and had completed Control of Substances Hazardous to Health (COSHH) risk assessments.

Staffing establishments were reviewed to keep patients safe and meet their needs. Where staffing issues had been identified, we saw that action plans were in place outlining how risks would be managed and work re-allocated. We saw that risks were assessed and mitigating actions

recorded to reduce and manage the risk. For example, none of the GP partners took annual leave during the Christmas and New Year weeks due to the predicted increase in demand for the service.

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 patients with complex long term conditions. 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. There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.The practice had plans in place to extend the use of this tool in April 2015 to help them to reduce the number of unplanned hospital admissions. There were emergency processes in place for identifying acutely ill children and young people and children were provided with on the day appointments when needed.

There were systems in place to review the number of patient admissions to A&E. The GP partners met every two weeks to discuss A&E attendances and admissions and to plan further care. For example, by comparing data with other practices in the region, the practice had identified there was a high emergency admission rate for children with chest infections. Following analysis of the reasons for this, it was identified that many of the practice's patients worked at the local hospital so it was more convenient for them to take their children there. The practice had worked with the hospital to educate patients in the most appropriate use of A&E. The practice also kept open appointments so that if one of their patients attended the neighbouring A&E department inappropriately, they would be re-directed back to the practice to ensure they received the most appropriate care and treatment.

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 medicines for the treatment of cardiac arrest, anaphylactic shock (a severe, potentially life-threatening allergic reaction that can develop rapidly) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This was available to all staff on the practice's intranet and hard copies were kept in the practice and at the homes of the GP partners. 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.

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 and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for managing a major emergency such as pandemic 'flu where a buddy system was in place with a neighbouring practice to ensure safe staffing levels.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. 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. However, the practice did not have a systematic way of reviewing and evaluating which NICE guidelines were appropriate for their patients or that NICE guidelines had been implemented.

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. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice used a risk assessment tool to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and patients receiving palliative care. We saw minutes from multi-disciplinary meetings confirming that the practice followed the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses, community matrons and social workers, took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of seven patients and alerts within the clinical computer system making clinical staff aware of their additional needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All the GPs we spoke with followed NICE guidelines for the referral of patients with suspected cancers to be seen within two weeks. We saw that an audit of cancer referrals had been completed which demonstrated that they were in line with the national average and that their processes were robust in ensuring early and appropriate referrals.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us four clinical audits that had been undertaken in the last two years. We saw that the prescribing of Citalopram (a drug used to treat depression) had been carried out. This was a completed clinical audit where the practice was able to demonstrate that the changes made in the prescribing of Citalopram, had improved health outcomes for patients. Other examples included audits to confirm that the GPs who undertook minor surgical procedures had done so in line with their registration and NICE guidance. A review of how complete the practice's dementia register was had also been carried out. We saw that complete audit cycles had not been completed in all clinical audits to evaluate that changes made had improved outcomes for patients.

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. For example, we saw that the percentage of patients with aged 75 years and over with a fragility fracture and were receiving the appropriate medication was above the national average. The practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and coronary heart disease.

Good

Are services effective?

(for example, treatment is effective)

The practice also participated in the local Clinical Commissioning Group's (CCG) Quality Improvement Framework (QIF). The QIF showed how improvements had been made across the area, for example in the area of blood pressure control. The senior GP partner showed us data from the QIF of the practice's performance for antibiotic prescribing. We saw that this was lower than the CCG average and demonstrated that the practice was proactive in monitoring the prescribing of antibiotics.

The practice used an urgent care dash board to monitor their patients A&E attendance. The practice had identified that they had a high hospital emergency admission rate for children with chest infections. Following analysis of the reasons for this, it was identified that many of the practices' patients worked at the local hospital making it more convenient for them to take their children there. The practice had worked with the hospital to educate patients in the most appropriate use of A&E. The practice kept open appointments so that if one of their patients attended the neighbouring A&E department inappropriately, they would be re-directed back to the practice to ensure they received the most appropriate care and treatment.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received 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 and that the latest prescribing guidance was being used. The practice participated in a process of bench marking their prescribing rates. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar practices in the area. The data we reviewed demonstrated that the practice was below or comparable with other practices in the region for the prescribing of anti-diabetic medicines and medicines to help patient to sleep.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to seven.

Effective staffing

Practice staffing included medical, nursing, counselling, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses identified by the practice, 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 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 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. 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 trainee 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, the administration of vaccines, cervical screening and ear irrigation. 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.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Good

Are services effective?

(for example, treatment is effective)

The practice held regular multidisciplinary team meetings with other services. For example, with the Health Visitor to discuss the needs of children registered with the practice or the district and palliative nurses to discuss the needs of patients receiving end of life care. Decisions about care planning were documented in a shared care record.

We saw that the practice had worked closely with the local learning disabilities facilitator to help the practice to co-ordinate their learning disabilities register and to support these patients to attend health assessment reviews. The practice also worked closely with MIND, Healthy Minds and Child and Adolescent Mental Health Services (CAMHs) to meet the needs of adults and children with complex acute mental health issues. We spoke with the named Health Visitor for the practice and they told us that they had a good working relationship with the practice that included the sharing of information and concerns they had about children registered with the practice.

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 made referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. 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. We looked at the training records the practice had provided to us for eight members of clinical staff. We saw that only one member of staff had received formal training in the MCA 2005 so staff could not be sure they were up to date with the most up to date guidance. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

All clinical staff demonstrated a clear understanding of Gillick competence. 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. Nursing staff told us how they considered Gillick competence when a young person attended for contraceptive advice. They showed us that they had guidelines immediately to hand to refer to if needed. Nursing staff described to us how they ensured that parents who bought their children for immunisations were provided with information to enable them to make an informed decision when providing consent. We saw that formal consent forms had been signed by parents.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

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.

It was not practice policy to routinely offer new patient health checks to all new patients who registered with the practice. However, there was a policy in place that enabled staff to identify new patients' needs. This included a patient registration form which included sections where patients alerted the practice to any specific needs they may have. This was overseen by the senior practice nurse and if a need was identified, such as the need for smoking cessation advice, the patient was sign posted to the appropriate agencies for support. New patients with long term conditions were added to the register for that condition and called in for a health review.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75 and travel vaccinations when needed. Older patients were provided with the 'flu vaccination either at the practice, or if house bound, at home. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of 31 patients with a diagnosis of dementia. They had carried out a recent audit to determine if their dementia register identified all the relevant patients. The results showed that most patients were on the register and action had been taken to contact those that needed further investigation.

Following analysis of their QIF data, the practice ran an annual health promotion event aimed mainly at patients from black minority groups who were at a higher risk of diabetes and cardiovascular disease. These were held in the evening to allow working age patients to access them. The evenings included healthy living advice and health monitoring such as weight, blood sugar and cholesterol testing by the GPs and nurses. Although the practice had not audited the effectiveness of these events in improving outcomes for patients, they had identified several patients with undiagnosed diabetes. This enabled patients to receive earlier diagnosis and effective management of related health problems.

The practice's performance for cervical smear uptake was 76% with a target of 80%, which was comparable with other practices in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

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 174 patients undertaken by the practice's patient participation group (PPG) in November 2013. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 94% of respondents said their overall experience was good or very good and 86% of respondents would recommend the surgery. These results were above the regional Clinical Commissioning Group (CCG) average. The practice was also above the CCG regional average for its satisfaction scores on consultations with GPs and nurses with 93% of practice respondents saying the GP was good at listening to them and 83% saying the GP gave them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 31 completed cards which were overwhelmingly positive about the service experienced. Patients told us the staff were always helpful, understanding, professional, very caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was an excellent practice and that it was always clean and tidy. Most patients told us the appointment system was easy to use and met their needs. We also spoke with four patients on the day of our inspection. All told us they were very 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 saw that consultation and treatment room doors were closed during consultations and that conversations that took place in these rooms was not overheard. Electronically adjustable examination couches were available in each consultation and treatment room. These could be elevated or lowered to support patients with mobility difficulties to maintain their independence and dignity when they needed to be examined.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. In response to the PPG feedback, chairs in the waiting room had been moved away from the reception desk area so patients could not overhear conversations. Patients also told us that the music played in the reception area prevented them from overhearing any conversations at the reception desk. A poster was displayed informing patients that if they wished to speak to a receptionist in private, a room would be made available. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and saw that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

The practices' website and patient information pack clearly stated the practice's zero tolerance for abusive behaviour. Staff told us that there were arrangements in place with the CCG to provide a security guard if there were concerns that a patient may become aggressive.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff described how they supported patients to access the practice without fear of stigma or prejudice. We saw that information was available informing patients from a minority ethnic background how they could access an advocate to support them in decisions about their care. The practice also employed a counsellor so that some patients experiencing poor mental health could attend their local GP practice for support rather than other mental health providers.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed from data published in July 2014, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% of practice respondents said the GP was good at involving them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above the CCG regional average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on 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. We saw notices in the reception areas informing patents this service was available.

There were 12 patients on the practice's learning disabilities register. We saw that all these patients had received an annual health review carried out using a health check template. There were 43 patients on the practices' register for patients experiencing poor mental health. There was a system in place to ensure that patients experiencing poor mental health received an annual health review. We saw there was a care plan template to enable GPs and nurses to plan the care for these patients. The practice held a register of patients with long term conditions which included patients with coronary heart disease; diabetes; chronic obstructive pulmonary disease and asthma. We saw that there was a system in place that ensured patients received an annual health review. The senior GP partner told us that appointment days and times for patients with long term conditions were flexible to accommodate patients' preferences. The Quality and Outcomes Framework (QOF) data that we reviewed showed that the percentage of patients diagnosed with dementia who had received a review of their care in the previous 15 months was in line with national standards.

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted staff 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. This was easily accessible at the reception desk. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. To do this, carers were offered additional health checks and the 'flu vaccination.

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. A GP told us that as a result of working closely with the families of patients nearing the end of their lives, they had developed a strong rapport with them. When a patient died, the GPs rang the families to offer an appointment or a home visit. There was information displayed in the waiting room informing patients of the bereavement services available in the local area. The practice counsellor was also available if it was appropriate to refer a patient to them for additional support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had identified that working age patients made up the greatest part of their practice population. We saw evidence that this population group was higher than the national average for GP practices. As a result of this analysis, the practice provided additional services such as enhanced contraceptive services, vasectomies and extended opening hours on Monday evenings and Saturday mornings.

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 was also a member of the GP Aruna federation that provided out of hours services on Thursday afternoons when the practice was closed. This meant that patients had access to GP services when the practice was closed.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. An example of responding to PPG feedback was how confidentiality in the waiting room had been improved.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning and we saw evidence of this. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that it was regularly discussed at staff appraisals and team meetings.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor of the building. 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. Facilities for patients with mobility difficulties included disabled parking spaces; electronic entrance doors to the practice; disabled toilets and a hearing loop for patients with a hearing impairment. If a patient was visually impaired, it was recorded in their records and the GP came out to fetch the patient to ensure they did not miss their appointment.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a telephone translation service to ensure patients were involved in decisions about their care. If a patient did not speak English, they were provided with a double appointment.

The practice provided care and support to several house bound elderly patients and patients living in three local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. GPs provided home visits and the practice nurses worked with the district nurses to provide home 'flu vaccinations to reduce the risk of seasonal infections. Patients with learning disabilities were provided with annual health reviews at the practice. If their learning disability prevented them from accessing the practice, a GP home visit was provided. The practice used easy read cards and leaflets to help patients with learning difficulties to understand and be involved in decisions about their care and treatment.

Access to the service

Appointments were available from 8am to 6pm on weekdays except Thursday afternoons when appointments were available up to 4.30pm. Extended access appointments were available Monday evenings until 8pm and Saturday mornings 8.30am to 12.30am. This supported working age patients and children and young people to access appointments outside of normal working hours. Patients could book appointments up to four weeks in advance either face to face at the practice, over the telephone or on-line by the practice's website. On the day appointments were also available if a patient needed to be seen urgently.

Comprehensive information was available to patients about appointments on the practice website and in the patient information pack. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical

Good

Are services responsive to people's needs?

(for example, to feedback?)

assistance when the practice was closed. If patients called the practice when it was closed, their call was diverted directly through to the out of hours service. Information on the out of hours service was provided to patients in the waiting room, in the patient information pack and through the practice's website.

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 to three local care homes to those patients who needed one. We spoke with representatives from two of the care homes who told us that that the practice was always responsive to the patients' needs and provided home visits on the day they were requested.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Data from the national GP survey supported this. Eighty-nine per cent of respondents stated they were able to get an appointment last time they tried and 81% described their experience of making an appointment as good. This was above the regional CCG average.

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 with complex long term conditions. Longer appointments were available for patients that needed them such as non-English speaking patients or carers.

The practice kept a register of patients who were experiencing poor mental health to monitor and inform service provision. The practice had identified there was a need for additional support for patients experiencing poor mental health and had employed an in-house counsellor to complement the annual health reviews carried out by the GPs and nurses. This enabled timely access to appointments for patients experiencing poor mental health. The practice also worked closely with MIND, Healthy Minds and Child and Adolescent Mental Health Services (CAMHs) to provide support for adults and children experiencing poor mental health.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This was displayed on the practice's website and in the patient information pack. However, the policy was not clearly displayed in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at seven complaints received in the last 12 months and found they were dealt in a timely manner and handled appropriately. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learnt from individual complaints had been acted on.

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 displayed on the practice's website. The practice vision and values included Excellent Care - Excellent Training – Excellent Service. The practice had clearly identified within their original strategy the need to move from their old premises to their new premises. This was to ensure that patients received care at a location that was safe and appropriate to their needs. The practice had moved in December 2012 to fulfil this vision. However, a revised strategy or business plan had not been put in place following the move.

We spoke with nine members of staff and they all knew and understood the vision and values. They knew what their responsibilities were in relation to these. We saw that staff worked effectively as a team to deliver these values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at several of these policies and procedures. We saw that they had been reviewed at regular intervals and were current and up to date. We saw that some policies, such as whistleblowing, that staff had completed a cover sheet to confirm that they had read the policy and when.

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 the senior partner was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. We saw that the team was an experienced team that worked effectively together.

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 it was performing above national standards by obtaining 97 QOF points out a possible 100. We saw that QOF data was regularly discussed at partners' meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of service wide audits which it used to monitor quality and systems to identify where action should be taken. This included for example, audits of infection control, complaints, significant events and minor surgery.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as loss of domestic services or information technology. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. However, the practice's risk management process had not considered the risks to the service if key staff members left the practice taking with them their knowledge and experience.

The practice held regular governance and clinical meetings. We looked at minutes and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that nursing and GP partner meetings were held on a regular basis. We saw that there was a notice board for clinical staff to add items to the agenda that they wished to discuss. Reception and administrative staff told us that did have regular meetings but they were informal and minutes were not recorded to enable reference to over time. 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and information governance, which were in place to support staff. Staff we spoke with knew where to find these policies if required. We were shown the staff handbook that was available to all staff and completed induction packs for new members of staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards, compliments and complaints. We looked at the results of the annual patient

Are services well-led?

Good

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

participation (PPG) survey. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. We saw that 16% of respondents did not feel there was enough privacy in the reception area and only 45% of patients were aware that there were facilities for private discussion with the receptionist. We saw as a result of this that chairs had been moved away from the reception desk area so patients could not overhear conversations. Patients also told us that the music played in the reception area prevented them from overhearing any conversations at the reception desk. A poster had been put in place informing patients that if they wished to speak to a receptionist in private, a room would be made available.

There was a "You said…..We did" display in the waiting room informing patients of the results of the PPG survey and what the practice had done to meet any issues identified. This information was also displayed on the practice's website.

The practice had an active PPG that consisted of seven members. All of the members were within a similar age range. The chair of the PPG told us that they had identified the need to ensure that there were representatives for all age ranges and were actively encouraging other patients to join the group. Six new members from the practice's virtual PPG had agreed to participate in the PPG and would be attending the next meeting. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website and on display in the waiting room. The chair of the PPG told us they felt valued by the practice the practice manager and GP partners were always responsive to their concerns.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 two 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 that they had guest speakers and trainers.

The practice was a training practice for medical students and GP registrars to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with one GP registrar on the day of our inspection. They told us they were well supported by the GPs and nurses and there was an ethos of training for all staff throughout the practice.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings and through the practice's 'task setting and instant messaging' computer system. This enabled the practice to improve outcomes for patients. For example, we saw that a patient had suffered a life threatening incident at the practice. Staff had taken the correct action and the patient survived. During the root cause analysis of the significant event, the value of the emergency call system was recognised. An action plan was put in place to ensure all staff were aware of how to activate the panic button on the computer for future emergencies. One member of staff told us how the practice carried out test panic alerts to ensure this system worked and staff had responded appropriately.