The Lawn 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Lawn Medical Centre is a large modern purpose built facility located south east of Swindon in Wiltshire. The practice has approximately 7,000 registered patients from an area immediately surrounding the practice and nearby villages. The practice age distribution is in line the national average with most patients being of working age or older. In 2013 the practice increased its patient numbers by 800 following the closure of a nearby practice. The practice has four consulting/treatment rooms on the ground and first floors. The practice is registered as a training practice.

We carried out an announced, comprehensive visit on 10 October 2014. During our visit we spoke with a range of staff. These included GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff.

We also spoke with patients who used the practice and we reviewed comment cards where patients shared their views and experiences of treatment and care provided by staff.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Swindon Clinical Commissioning Group (CCG), the NHS England local area team and Healthwatch Swindon.

The overall rating for the Lawn Medical Centre is GOOD. Our key findings were as follows:

- Patients felt they were treated with kindness and professionalism.
- Systems were in place to report and record safety incidents, including concerns and near misses, and to learn from them.
- The practice was clean and tidy, and infection prevention and control protocols were implemented.

We saw OUTSTANDING practice:

Summary of findings

- A senior practice nurse was the accredited cytology trainer for the Swindon area.
- A practice nurse was a National DESMOND Diabetic Trainer for the delivery of courses for diabetic patients.

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

The provider SHOULD:

- Ensure all nursing staff fully understand, and apply in practice, the requirements of the Mental Capacity Act 2005.
- Ensure all recruitment checks are undertaken and the evidence kept on file.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and generally well managed, although recruitment checks were not always complete.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice could identify all appraisals and the personal development plans for staff. Multidisciplinary working was evidenced. There was an awareness of Mental Capacity Act 2005 and evidence of training in this but the requirements of the legislation were not fully understood by nursing staff.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of its local population. Patients reported good access to the practice and having a named GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had inductions, received 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 for 2013 showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. There were enhanced services for patients over the age of 75 with regard to unplanned admissions. All patients eligible for this service had detailed care plan in place and the practice demonstrated they met their needs. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those who needed it and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were met. For those people 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 population group of families, children and young people. Systems were in place for identifying and following-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 and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 so they were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances which included those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 90% of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients 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. The practice had in place advance care planning for patients with dementia.

The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up patients who had attended accident and emergency where there may have been mental health needs.

Summary of findings

What people who use the service say

We spoke with nine patients and received 26 comments cards from patients who had visited the practice in the previous two weeks. Patients were positive about the staff and the care and treatment they received and spoke highly of all the staff. All patients told us they had enough time to discuss their concerns and were given information and support to understand their condition and the treatment options. Patients were complimentary about the GPs and other staff in the practice. The felt treatment they received was provided in a safe and effective way. They also told us they found the environment was always clean and tidy and clinical staff, particularly nurses, wore protective equipment such as gloves and plastic aprons during personal examinations.

The practice results for the national GP patient survey in 2014 were higher than the national average. Information on the practice website showed 76% of patients were very satisfied with the practice and 18% of patients were fairly satisfied with the practice.

A 'friends and family test' survey had recently commenced to find out if patients would recommend the practice to other people. This survey showed 89% of patients were 'extremely likely' or 'likely' to recommend the GP practice. A similar percentage of patients also rated the treatment received from the GP they saw as 'very good'.

Areas for improvement

Action the service SHOULD take to improve
The provider should:

- Ensure all nursing staff fully understand, and apply in practice, the requirements of the Mental Capacity Act 2005
- Ensure all recruitment checks are undertaken and the evidence kept on file.

Outstanding practice

We saw outstanding practice:

- A senior practice nurse was the accredited cytology trainer for the Swindon area.
- A practice nurse was a National DESMOND Diabetic Trainer for the delivery of courses for diabetic patients.

The Lawn Medical Centre

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 a practice manager specialist advisor.

Background to The Lawn Medical Centre

The Lawn Medical Centre is a large modern purpose built facility located south east of Swindon in Wiltshire.

The practice has about 7,000 registered patients from an area immediately surrounding the practice and nearby villages. The practice age distribution is in line the national average with most patients being of working age or older. In 2013 the practice increased its patient numbers by 800 following the closure of a nearby practice.

The practice closes to patients each Wednesday afternoon and operates on-call cover through a shared cared arrangement with another, local practice in Swindon. Details of this cover are given by an answerphone message when patients ring the Lawn Medical Centre after 2pm**.**

The practice had four consulting/treatment rooms on the ground and first floors. There were management, meeting and training areas on the first floor. The practice was registered as a training practice.

There were four partner GPs and two salaried GPs who were part of the practice team. A team of four nurses, a health care assistant, and a phlebotomist provided a range of nursing services and clinics. In addition there were five administrative and reception staff who supported the day to day running of the practice.

The practice has opted out of providing Out-of-Hours services to its own patients. Instead, this service is available from another healthcare provider.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Detailed findings

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 October 2014. We spoke with GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff. We also spoke with patients who used the practice and we reviewed comment cards where patients shared their views and experiences of treatment and care provided by staff.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example a patient identified that on one occasion in 2013 an incorrect prescription was given to them by the reception team when the patient called to collect it. As a result, the practice reviewed the prescription process used at the reception desk including the keeping and filing of requests for prescriptions.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last twelve months and these were made available to us. We looked at the serious incident reviews for the last twelve months and saw that there had been eleven serious incidents during the year. Each incident had an improvement action plan that was recorded as completed. There were no reoccurrences of any individual serious incident.

We reviewed safety records and incident reports and the minutes of the weekly practice meetings where these were discussed. All serious adverse events, previously called significant events, were investigated appropriately in line with the practice policy. We read in the incident log that a patient presented at the practice with shortness of breath and chest pain while waiting in the practice. It was quickly recognised by reception and the patient was fast tracked to see a GP and taken to hospital. The practice investigated the incident and identified lessons to learn regarding their management of acute emergencies. The lessons were shared with the practice team at the weekly practice meetings.

Learning and improvement from safety incidents

A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred weekly to review actions from past significant events and complaints. There was evidence that learning from significant events had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. The significant event proforma used to record events was detailed. It included discussions, learning outcomes and actions, and evidence of action taken as a result. One significant event recorded was of the prescription printer breakdown in the main reception office for several days. This led to some delays in prescriptions being issued. The practice reviewed its processes and developed a new protocol which included allowing set times for printers to cool during busy periods and calling IT support earlier. Staff confirmed there were no further breakdowns.

National patient safety alerts were disseminated by the practice manager and their secretary/assistant to practice staff. Staff told us there was a system of prioritising alerts which had specific impact on GPs to ensure GPs were made aware of them quickly. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were to ensure all staff were aware of any issues relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for social services were easily accessible.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary

training to enable them to fulfil this role (level 3 in protecting children). Staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff were aware of any relevant concerns when patients attended appointments. For example, there were electronic alerts to remind GPs which children had a child protection plan with the local authority. There was also a safeguarding protocol which included the protection of vulnerable adults and other groups such as patients with a learning disability. There was an electronic coding system for the identification and follow up of children, young people and families living in any disadvantaged circumstances (including looked after children, children of substance dependent parents and young carers). There was also an electronic system for identifying children and young people with a high number of A&E hospital attendances. GPs we spoke with confirmed they liaised with partner agencies like the police and social services to protect vulnerable children. They were invited to children protection case conferences and reviews but GPs told us they did not routinely attend these. The practice nurses had a system to follow up children who persistently failed to attend appointments e.g. for childhood immunisations.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as a chaperone then trained non clinical staff took their place. All staff who acted as chaperones who we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. Patients spoken with confirmed they knew they could request a chaperone.

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. We saw fridges were situated in a secure area and minimum / maximum temperatures recordings were maintained with no temperature outliers observed.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There was a system is in place with pharmaceutical advisors from the clinical commissioning group for the disposable of out of date stock. We saw the register of disposed medicines was well maintained.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. The monitoring and maintaining of medicines held in GP bags was managed by the lead nurse who had a schedule for checking and restocking medicines. We saw dressings available for named patients were well maintained and stored appropriately.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Staff knew both sets of directions and there was evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updating in the specific clinical areas of expertise for which she prescribed.

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 generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to patients. Blank prescription forms were

Good

Are services safe?

handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Any incidents relating to prescriptions were placed on the risk register and investigated.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were monitored by the practice manager. 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 thereafter annual updates. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed. We saw the audit in 2013 had all identified actions completed. There was a system of inspection / audit in place with external involvement from the clinical commissioning group.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. For example all staff could demonstrate effective hand washing. There was also a policy for needle stick injury.

Hand hygiene techniques signage was 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). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. The most recent Legionella risk assessment was completed in September 2013 undertaken by an external company who provided monthly monitoring certificates, a log and an annual risk assessment.

Equipment

Staff we spoke with told us they had sufficient 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. For example we saw evidence of calibration of equipment in the treatment room, for example, the sphygmomanometer (blood pressure gauge), weighing scales, and doppler (equipment to see how blood flows through a blood vessel). We saw the portable appliance testing and calibration testing were carried out annually by an authorised independent company. A schedule for testing equipment was in place.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff. We reviewed eight staff files including those of salaried GPs, nursing and administrative staff. We saw inconsistent evidence of references and proof of photo identification having been obtained. We were told the references and photo identification were seen by the practice manager before the in house Smart Card (practice identification cards) was issued but copies were not kept. There were criminal records checks risk assessment guidelines, a form and tool kit to assist staff in determining whether a criminal records check through the Disclosure and Barring Service (DBS) was required for members of 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 a rota system in place for different staffing groups to enable the practice to plan and monitor the number of staff on duty. The reception team's hours reflected the busiest times within the practice and staff worked extra hours if required for sickness or holiday cover. They also shared the rota for the Saturday morning surgery. There were arrangements in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written into their contracts.

Good

Are services safe?

Staff told us there were always enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & 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.

Identified risks were included on a risk log. Each risk was assessed 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 the recent findings from a health and safety audit with the team. The practice had an arrangement with the local hospital's occupational therapy department for carrying out risk assessments.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment. Records we saw confirmed the equipment was checked regularly. In the notes of the practice's significant event review records we saw that a medical emergency concerning a patient who had a suspected heart attack had been discussed and learning had taken place.

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 and hypoglycaemia. Processes were also in place to check 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 could 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. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. The practice had a fire policy in place and annual fire certification by the fire brigade with a completed action plan. The fire alarms were tested monthly by a maintenance company and full evacuation exercises took place twice yearly. We saw records of staff evacuation exercises to ensure staff understood how to effectively evacuate themselves and patients in the event of a fire.

Risks associated with service and staffing changes like staff sickness were included on the practice risk log. For example the practice had an additional 800 patients in 2013. This was identified as a risk to the provision of services and mitigating actions were put in place by the practice. For example, the practice increased the working hours of the salaried GP by two sessions. The practice also recruited a further practice nurse, increased the hours of other practice nurses and the phlebotomist.

The training schedule for all staff at the practice confirmed mandatory training had taken place in areas like cardiopulmonary resuscitation (CPR). GPs, practice nurses and administrative and reception staff were updated yearly. GPs or staff joining between update sessions were trained at other practices as spaces were available. A register of this training was held by the practice manager.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They told us there was an ethos of evidence based medicine inspired by the training status of the practice.

Medical staff were familiar with current best practice guidance accessing 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 disseminated. The implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Staff told us this arrangement allowed the practice to focus on specific conditions. For example in the treatment of diabetes the initial giving of insulin (hormone that lowers the level of glucose in the blood) to patients was initiated by the practice nurse under the leadership of a GP. There were no dedicated clinics for patients with diabetics as they were seen in routine nurse consultations with an additional thirty minutes allocated for a diabetic annual check and treatment plan review. In the treatment of chronic obstructive pulmonary disease (COPD) the lead was a practice nurse who was a trained respiratory nurse.

Patients with asthma were managed by the practice nurse team. A named nurse was the nurse prescriber for both asthma medicines and contraception. The nurse managed patients with a urinary tract infection (UTI) and prescribed medicines for its management and treatment. Patients with a learning disability were assessed and seen by the practice nurse who undertook health check and completed relevant bloods checks. Patients who received palliative care were supported by the practice with support from the local hospice. Feedback from patients we spoke with confirmed this worked well and gold standard framework (GSF) meetings occurred regularly. Patients with drug and alcohol dependencies were treated by GPs with specialised training.

Mothers and babies were assisted by the practice's midwife. The two mothers we spoke with praised the services received during their pregnancy and the timely immunisation and post natal care received. They were very complimentary of the care they experienced. For patients with poor mental health there was an in house counsellor who accepted patient self-referral to assist patient autonomy. Their waiting time was two weeks so patients received a timely service.

GPs and nurses we spoke with said they felt comfortable about asking for and providing colleagues with advice and support. For example, GPs told us the practice's team working supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

Data from the local clinical commissioning group (CCG) showed the practice's antibiotic prescribing was comparable to that of similar practices.

Patients with long term, complex needs patients on warfarin were managed jointly with the local anticoagulation unit. The practice used computerised tools 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. The protocol required patients to be reviewed by their GP according to need.

National data showed the practice was in line with referral rates to hospital and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that improvements to practise were shared with GPs and nurses. The practice assessed patients with long term conditions and multi-morbidities for anxiety and depression and made referrals to support agencies.

Good

Are services effective?

(for example, treatment is effective)

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 based 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 the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. In both of these completed audits the practice was able to demonstrate changes resulting since the initial audit. For example the practice had completed an audit cycle starting in August 2014 to review the fitting of a contraceptive implant and removals over the last two years. The practice found that its recording systems were sound but identified that some patients did not make appointments to remove the implant. The practice then implemented a system of automatically recalling patients to have the implant removed to further improve patient safety. Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of audit of a specific contraceptive implant and there was clear evidence of reflection from the lead GP in this audit. Following the audit, the other GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented any changes.

Effective staffing

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. The practice used a pre appraisal form given to staff prior to the appraisal to give them time to consider what they wish to discuss at the meeting. We saw appraisal meetings included measurable objectives for staff, for example, attending specific training.

Staff interviews confirmed that the practice provided training and funding for relevant courses.

For example, two receptionists had attended training courses in customer care. As the practice was a training practice, trainee GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive. Administrative and reception staff participated in a programme of training which allowed the practice manager to tailor training programmes to individuals' needs. Staff were then able to work through computer package modules and the practice manager could track their progress.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, nurses were trained in travel health and offered required vaccinations to patients. Nurses were also all trained in cytology and the senior practice nurse was the accredited trainer for the Swindon area.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and Out of Hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers. The GP

Good

Are services effective?

(for example, treatment is effective)

reviewing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The practice worked closely with the local hospital and there was a policy for actioning hospital communications. The practice policy required a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The records we saw showed there were no instances within the last year of any results or discharge summaries which were not followed up.

The practice was commissioned to provide enhanced services (enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). Enhanced services offered by the practice included minor operations, joint injections, contraceptive fittings & hormone injections. The practice also offered the full range of available immunisations which were not enhanced services, for example, flu clinics and shingles vaccines.

There were bi-monthly primary health care team meetings with the practice's GPs and nurses, district nurses, health visitors and representatives from the local hospice to discuss the needs of complex patients with end of life care needs. This is known as a gold standards framework meeting and was used to share information and care data regarding certain patients. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example communication with the local hospital about patient admissions. Electronic systems were also in place for making referrals, and the practice could make 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). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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. The clinical meetings included information sharing about patients. The practice meetings attended by all the staff team discussed wider issues about the practice such as training events.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. There was an awareness of MCA and evidence of training among the GPs but it was not fully understood by the nursing staff.

All the GPs we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where a patient's capacity to consent was a concern, the practice had drawn up a policy to help staff, for example, with making 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice offered an annual health check to all patients with a learning disability. This was done by a recall system and was managed by the senior partner and a practice nurse. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and stated the patient's preferences for treatment and decisions. When interviewed GPs gave examples of how a patient's best interests were taken into account if a patient did not have capacity to consent to care or treatment.

We saw the practice 'Confidentiality (teenagers) Policy'. We spoke with a GP partner who demonstrated an understanding of confidentiality for patients who were under 16 years old. They told us they had experience of using Gillick competency when assessing or providing care or treatment to children. GPs and nursing staff demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Good

Are services effective?

(for example, treatment is effective)

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.

The practice had not had an instance where restraint had been required in the last three years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

Patients we spoke with told us they were encouraged by the GPs and nurses to follow healthy lifestyles. Patients diagnosed with diabetes or high blood pressure were given information and advice about managing their conditions from their GP or nurse. GPs and nurses told us that where they identified potential risks to a patient's health or well being, they provided them with information leaflets and advice.

Staff told us it was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of identified concerns and these were followed-up by the GP. We noted a culture amongst the GPs of using their contacts with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients who had risk factors for disease identified at their health check were followed-up and scheduled for further investigations.

The practice identified patients who needed additional support and was pro-active in offering additional help when patients needed it. For example, the practice kept a register of all patients with learning disabilities and 100% of these patients were offered an annual physical health check. Practice records showed 93% of patients had received a check up in the last 12 months. The practice had also identified the smoking status of 95% of patients over the age of 16 and they offered nurse led smoking cessation clinics to these patients. Similar mechanisms for identifying at risk groups were used for patients who were deemed to be clinically obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was better than 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 did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening was better than other practices in the CCG area and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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 immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse. Patient uptake for all three cancer screening programmes was higher than the local CCG and England averages. Breast screening uptake was 78.8%, cervical screening was 84.6% (highest in the CCG area) and bowel screening was 62.6%.

All patients with long term conditions such as diabetes and asthma were invited for an annual review. The practice had adopted the system of summary care records and we saw evidence of health promotion and lifestyle advice in the waiting area and GPs told us the information was also in patient notes. The practice also ran a specialist service/ clinic for patients with diabetes. The practice offered an enhanced service to identify patients at risk of developing long term conditions.

For patients with mental health concerns, 66% of patients on their mental health register had a care plan. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Patients aged over 75 with mental health problems who attended A&E were offered follow up appointments within three days of attending the hospital.

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 of 384 patients undertaken by the practice's patient participation group (PPG). The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was above average for its satisfaction scores on consultations with GPs and nurses with 80% of practice respondents saying the GP was good at listening to them and 82% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients spoke highly of the services they received and praised the professionalism and helpfulness of staff. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and felt their dignity and privacy was respected. Three patients told us they felt they had to wait too long for appointments. Four patients told us they were not concerned about the wait because they knew once they got in to see the GP they were not rushed and were given as much time as they needed.

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 observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. The practice switchboard was located in a room behind the reception desk which helped keep patient information private. One patient told us they found it difficult when there was no one in the reception area and they had to wait for staff in the administration office to see they were waiting. Three patients told us the receptionists came quickly when patients were waiting.

In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. There were clear demarcation lines painted on the floor indicating where patients should stand. Staff told us this was intended to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted patient confidentiality was maintained.

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

Decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the national patient survey showed 70% of practice respondents said the GP involved them in care decisions and 70% 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. We saw notices in the reception areas informing patents this service was available.

In relation to older patients and patients with long term conditions we saw evidence of care plans and patient involvement in agreeing these. Patients were given detailed information about end of life planning.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient 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, 70% of respondents to the PPG survey said they were helped to access support services to help them manage their treatment and care. The patients we spoke with on the day of our inspection and the comments we received were consistent with this survey information. For example, one member of the PPG told us how GPs had responded compassionately when they needed help and provided support when required. They told us both the treatment they received had a significant and positive impact on their life.

Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations. The PPG stressed how the practice had organised the information in waiting room to make it easier to find. For example information about long term conditions like 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 families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Staff told us sympathy cards were sent to bereaved families. The practice recognised isolation as a risk factor and support was provided to address this, for example, access to counselling and information about social groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people's 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. The practice used a risk assessment tool which helped GPs detect and prevent unwanted outcomes for patients. The tool helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities. As a result of the population needs it identified, the practice prioritised services around urgent care, cancer identification, self-care and prevention, carer support, children, long term conditions, end of life care, mental health and learning disability services.

The practice offered personalised care to meet the needs of the its patient population and had a range of enhanced services. These included care of homeless patients, contraceptive implants, minor surgery, coils and Insertions. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those who needed it and home visits.

There was very little turnover of staff in the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were 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 one local care home on a specific day each week, by a named GP and to those patients who needed one.

The practice's patient participation group (PPG) included members from a diverse background. We were told the group had been running for three years and consisted of 89 "virtual" members and fourteen "face to face" members. The group had twelve patients of other nationalities, a manager of a care home on behalf of those with learning disabilities, a resident of a care home, two wheelchair users, a patient with sight impairment, and a patient who was profoundly deaf.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). The PPG asked the practice to consider whether the practice's opening hours met patients' needs. As a result the practice increased the working hours of the new partner, salaried GP and recruited an extra nurse.

Following feedback from its own patient survey in 2013 the practice manager initiated online booking of appointments and requests for repeat medication. The practice also changed its appointment booking system to allow patients to book appointments up to four weeks ahead.

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 patients' and their families' care and support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice arranged with the local pharmacy for prescriptions for certain vulnerable patients to be delivered to their home address. There was also a regular home visiting regime for certain patients who, for example, could not travel to the practice.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff meetings. There was a register of patients who were thought to be living in vulnerable circumstances and there was a system for flagging vulnerability in individual patient records. Patients with no fixed address were able to register with the practice.

The premises and services had been adapted to meet the needs of patients with disabilities. There was wheelchair access and toilet facilities which were accessible to patients with restricted mobility.

Access to the service

The practice was situated on the first and second floors of the building with patient waiting rooms on both floors. Lift access was provided to the first and second floors. 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 facilities were available for all patients attending the practice including baby changing facilities. Staff told us the majority of the patients who attended the practice were English speaking but translation services were available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available from 8:30am to 6pm daily except on Wednesdays when the practice closed at 2pm. On-call GP cover was available from 8am to 6:30pm daily and the practice shared an on-call arrangement with another practice after 2pm on Wednesdays. The practice was also opened from 8:30am to 11:30am on Saturday mornings.

At the inspection, two mothers with children under the age of two years told us about the difficulties they had in accessing care on a Wednesday afternoon. Both mothers told us they were directed to the walk in centre instead of being seen by a GP when they called for help. One mother was then directed by the walk-in centre back to the practice which they found frustrating.

We spoke with the practice manager who told us that the GPs held a practice meeting between the partners and the practice manager from 3pm to 5:30pm each Wednesday. However GPs could also carry out medicals, call patients or carry out home visits. There was receptionist cover until 3pm which was available to deal with any urgent faxes or prescription issues**.** We looked at the log of complaints and saw there were no complaints about the opening times of the practice. The practice manager told us if patients complained about their opening hours then they would review the matter.

Information about appointments was available to patients on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 95% of patients who completed the practice's survey were able to get an appointment to see or speak to someone the last time they tried. The practice had a daily GP triage system where a GP would ring patients and assess whether they needed to visit the practice. This was GP led and patients told us they valued talking directly to a GP and many of their concerns could be dealt with immediately without the need to talk to other staff or visit the practice. The practice operated a system of pre-booking of appointments and book on the day appointments.

Patients were generally satisfied with the appointments system. Of patients who completed the national patient survey, 74% said they were usually able to see their preferred GP. This was 16% higher than the national average. 44% felt they did not normally have to wait too long to be seen by a GP. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice. 51% patients who completed the patient survey said they usually waited 15 minutes or less after their appointment time to be seen. This was 16% lower than the national average detailed in the national patient survey 2013. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances of their call. Information about the Out-of-Hours service was provided to patients.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures was 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 in the waiting room and on the website. The practice manager produced an annual summary of complaints for 2013 / 2014. There was a system for recording the receipt of the complaint, the action taken by the practice and also the response sent to the complainant. Advice for patients on the complaints procedure was available on the practice website, included in their newsletter and available at reception. None of the patients we spoke with had needed to make a formal complaint about the practice.

We looked at the seven complaints received by the practice in the last 12 months and found these were handled in line with the practice complaints procedure. For example, one patient complained about the timing of the removal of their stitches which had caused them some distress. The practice investigated the complaint and this resulted in a reminder to staff of the procedure for removing stitches and a procedure for double checking consultant letters from the local hospital. In another case, two patients had complained about the attitude of a locum GP. This was investigated on the day of the complaint and at a practice meeting the following week. The records showed the complaint was resolved to the complainant's satisfaction.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints on an annual basis to identify themes or trends. We looked at the report for the last review and no themes had been identified although lessons learnt from individual complaints had been acted upon.

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 that details of the vision and practice values were part of the practice's five year business plan. The practice vision and values included offering an efficient, friendly, caring, good quality service that was accessible to all patients.

We spoke with seven members of staff and they all knew and understood the practice's vision and values, and knew what their responsibilities were in relation to these. We looked at minutes of practice meetings and saw that staff had discussed the vision and values of the practice.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at seven of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All seven policies and procedures we looked at were reviewed annually and were up to date.

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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards, above the national average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example, we saw an audit of patient joint injections conducted between February 2013 and October 2013. Computer searches were used to identify patients who were coded as having had a joint injection (minor operation) administered by a GP at the practice in the period 1 February and 31 October 2013. The total number of patients identified by the search was 66. These patients were contacted by post and sent a questionnaire to complete and return. This form asked them which GP performed their injection, if it was effective, and how quickly. The practice concluded that the provision of joint injections should be kept under regular review to ensure GPs at the practice remained competent in performing this procedure.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the practice's risk log. It addressed a wide range of potential risks, for example, those associated with patients receiving occupational therapy. We saw that the risk log was regularly discussed at team meetings and updated. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example risks associated with legionella were assessed in September 2013 by an external company.

Leadership, openness and transparency

We were shown a clear leadership structure which had 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 eight members of staff and they were clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice. They also said they had opportunities to raise concerns at team meetings. We noted that team away days were held every six months.

The practice manager was responsible for human resources policies and procedures. We reviewed a number of policies, for example disciplinary procedures, the health and safety policy, and management of sickness which were in place to support staff. We were shown the electronic staff policies and procedures that were available to all staff, these included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the national GP annual patient survey and 60% of patients indicated it would assist them if they had more information about the practice's Out-of-Hours provision and other healthcare provision in

Are services well-led?

Good

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

the local area, for example, walk-in centres. Staff told us that as a result of this feedback, the practice had compiled a list of Out-of-Ours health services, produced a notice about these services, replied to those patients who raised it as an issue, and produced a newsletter with information about the available services. Patients we spoke with said they knew about the Out-of-Hours provision at the practice.

The practice had an active patient participation group (PPG). It included representatives from various population groups, including retired patients, parents and patients with long term conditions. The PPG carried out annual surveys and met every six months. The practice manager showed us the analysis of the last patient survey, from 2013, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through regular staff away days and 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.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five 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 staff away days where guest speakers and trainers attended. Staff were supported and encouraged to go on training courses paid for by the practice. All staff reported a supportive learning environment.

The practice was a GP training practice. Two experienced GPs at the practice were designated as trainers. One GP showed us their weekly rota which involved regular teaching of trainee GPs.

The practice completed reviews of significant events and other incidents and shared learning with staff via meetings and away days. For example, the practice identified three incidents of misdiagnosis of patients in the last year. Each case was investigated and discussed with all the GPs at the weekly practice meetings. In one case involving the treatment of a young child, the GPs reviewed the ways they could improve their diagnosis and treatment. There was a system in place to monitor and ensure there were no further incidents.