St Paul's Practice

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

This was a comprehensive inspection of St Paul's Practice and was carried out on 28 October 2014.The practice was well led by the GP partners and the practice manager. We rated this practice as good overall. We found good practice in the way the practice responded to the needs of people with long term conditions, providing them with effective care and treatment. The practice had responded to the needs of working patients and those patients who had barriers to accessing GP services such as those living in care homes.

Our key findings were as follows:

- The practice was rated highly by patients who described the overall experience of the practice as good or very good.
- The practice provided GP appointments at times that met the needs of their patients.
- The practice was able to offer specialist clinics to patients to avoid the need to attend hospital.
- There were effective infection control procedures in place and the practice building appeared clean and tidy.
- The practice manager had actively sought feedback from all staff about the practice, the training for their role, their expectations of a practice manager and suggestions for improvements to the practice.

We saw areas of outstanding practice including:

- The practice continually audited their service to improve the service they offered to patients. This included the weekly auditing of appointments with a constant review of staffing levels to reduce the waiting time for routine appointments.
- There was a system of regular whole staff training and weekly role specific training.

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

The provider should:

- Ensure that all equipment which may be needed in an emergency such as syringes and needles are in date.

Summary of findings

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff had received up to date training in safeguarding and were focused on early identification and referral to local safeguarding teams.

There was evidence of the safe management and auditing of infection control within a clean and well maintained building.

Arrangements were in place to deal with emergencies and major incidents. Staff were trained and there was appropriate equipment and medicines available to deal with a medical emergency. A detailed business continuity plan was in place to deal with any event which may cause disruption to the service.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed systems were in place to ensure that all GPs and nurses were up-to-date with national guidelines and other locally agreed recommendations. The provider had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audit cycles had been completed, which had resulted in improvements to patient care and treatment. We saw data that showed that the practice was performing well when compared to neighbouring practices. The practice had used proactive methods to improve patient outcomes and it had links with other local providers to share best practice.

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. Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients

Views of other healthcare professionals were very positive and aligned with our findings.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised.

The practice reviewed the needs of their local population and engaged with the NHS local area team and clinical commissioning group to secure service improvements where these were identified.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which had quality and patient satisfaction as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. The practice had an active patient participation group and proactively sought feedback from staff and patients and this had been acted upon. The practice manager had asked for feedback from all staff about the practice, their role, suggestions for improvements to the practice, how well trained they felt for their role and suggestions for efficiency.

There was a clear leadership structure and staff felt well supported by the GPs and practice management. The practice had an established staff team and a culture of openness and honesty was encouraged. Staff had received induction, regular performance reviews and felt communication throughout the practice was good. The practice arranged a training session for all staff every two months and each week there was an hour put aside for role specific training.

There was a weekly audit of appointments with a constant review of staffing levels. The staff mix and hours had been analysed against other local practices and adjustments made to reduce the time patients had to wait for a routine appointment.

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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet patients' needs. There was good communication with other health care providers and regular multi-disciplinary meetings to ensure the needs of these patients was met. For example the practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care. Data showed that last year the number of patients over 65 who received the seasonal flu vaccination was above average for the local clinical commissioning group.

Each patient over 75 years of age had a named GP and were able to see any GP of their choice for continuity of care when necessary or specialised care and treatment if needed. Patients in care homes received home visits, whenever possible, by their own GP in addition the GPs used these visits to speak with or monitor the health of any of their other patients who lived in the same care home.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions. The practice was aware of those patients with long term conditions and was able to provide longer appointments or home visits were needed. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the patient's 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 good for the care of families, children and young people. The practice had good relationships with the midwifery and health visiting teams patients told us that the GPs communicated well for continuity of care with the midwifery and health visiting team who had clinics at the practice. Immunisation rates high for all standard childhood immunisations with 90% of eligible children having received their vaccinations. Parents who failed to attend to attend with their child for vaccinations received a telephone call and were also sent reminders. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals.

Summary of findings

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 practice had adjusted the services it offered to ensure these were accessible to patients in this population group. The practice was proactive in offering online services, for example appointments could be booked and repeat prescriptions requested via the practice web page. Health promotion and information in relation to health screening was available which reflected the needs of this group. The practice was aware of the large student population and proactively encouraged students to take advantage of the relevant health screening and vaccinations that were available.

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 with learning disabilities. The practice carried out annual health checks for patients with learning disabilities these checks were co-ordinated by the practice so that each patient had sufficient time with the practice nurse and their GP.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

Patients experiencing poor mental health had a named GP for continuity of care. The practice had sign-posted patients experiencing poor mental health to resources such as online cognitive behaviour therapies and counselling services which were provided by a service which used rooms in the practice building. The practice supported students experiencing poor mental health to source additional educational support to help them with their studies.

Summary of findings

What people who use the service say

We spoke with nine patients and five representatives of the patient reference group (PRG). We reviewed 12 comment cards which had been completed by patients in the two weeks leading up to our inspection.

Patients were very complimentary about the practice staff who they said were patient, understanding and friendly. All but one praised the caring attitude of the GPs and their ability to respond to their patients' needs promptly with compassion and understanding. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions and people aged over 75 years of age.

Patients told us that staff had a caring attitude and they felt safe with the care they received. Patients were satisfied with the appointment system and the ability to get appointments to suit their needs. Patients told us that the nurse triage system worked well and that extended opening times helped to fit around work or caring responsibilities.

There had been 195 responses to the patient satisfaction survey that the practice had conducted in January 2014. This survey showed that 93% of the patients who responded would be extremely likely or very likely to recommend family or friends to the practice. The practice was rated highly by patients for the respect they were shown, their confidence in the ability of the GP or nurse and 96% of those who responded rated their ability to listen as extremely good or very good. This data was in line with data we saw from the National Patient Survey where 94.7% of the patients who responded rated their overall experience of the practice as good or very good.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that all equipment which may be needed in an emergency such as syringes and needles are in date.

Outstanding practice

- The practice continually audited their service to improve the service they offered to patients. This included the weekly auditing of appointments with a constant review of staffing levels to reduce the waiting time for routine appointments.
- There was a system of regular whole staff training and weekly role specific training.

St Paul's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a CQC Inspection Manager and a specialist advisor in practice management.

Background to St Paul's Practice

St Paul's Surgery is located in Alison Way close to the centre of the city of Winchester. The practice is operated from a spacious surgery purpose built in 2001premises which is owned by the GP partners. The practice building has ten consulting rooms, three treatment rooms. There is space for allied clinical services to use the consulting rooms. Other health care professionals use the premises with the community nursing team have permanent office facilities in the building. A pharmacy leases part of the building this service is not operated or managed by the GP partners.

The practice does not provide an out of hours service for their patients. Outside normal surgery hours patients are able to access urgent care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 15,400 patients. Patients are supported by 10 GP partners and one salaried GP. The practice provides 72 GP sessions per week. Further support is provided by a practice manager, four practice nurses and administrative and reception staff. The practice is a member of the West Hampshire Clinical Commissioning Group (CCG).

St Paul's Practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

West Hampshire CCG covers a significantly less deprived area than the average for England. St Paul's Practice covers an area equal to the least deprived 10% of England.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this practice 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 practice, 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as; the local NHS England, Healthwatch, West Hampshire Clinical Commissioning Group to share what they knew.

Detailed findings

We carried out an announced visit on 28 October 2014. During our visit we spoke with a range of staff including GPs, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service and representatives of the Patient Reference Group (PRG). We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 12 comment cards where patients had shared their views and experiences of the practice.

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

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

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

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

St Paul's Practice profile is broadly in line with the average for England. However they are situated near to the University and serve a large student population. The practice has increased in size by 7.5% in the past 18 months.

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.

We reviewed the significant events that had been recorded by the practice over the last 18 months. There were no recorded medication errors. Potential safety incidents had been acted on promptly and cascaded to practice staff to mitigate future risks. There was evidence that significant events had been handled appropriately to protect the safety and well-being of patients.

Weekly clinical meetings were used to highlight and discuss any patient safety or medicine alerts which had been received to ensure verbal and written information was passed to appropriate staff, GPs and nurses. This showed the practice had managed these consistently over time and so could evidence 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. Records were kept of significant events that had occurred and a record of the last 18 months was made available to us. A slot for significant events was on the partners' weekly meeting agenda, this provided staff with the opportunity to discuss any incident and to record any actions. A dedicated annual meeting took place to review actions from past significant events and complaints. Although significant events and complaints were appropriately reviewed and acted on we found that records such as minutes of meetings, where significant events had been discussed, and the annual summary of significant events were not clear about the learning from these events to reduce future risks

There was evidence that the findings from significant events and complaints were disseminated to relevant staff. For example when information had been scanned into an incorrect patient record there had been a review of the scanning process. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues and felt encouraged to do so.

Incident and complaint forms once completed were dealt with by the practice manager who showed us the system they used to oversee these were managed and monitored. We tracked a number of incidents and saw records were completed in a comprehensive and timely manner. The record of complaints and significant events showed that these had all been responded to or discussed at partners' meetings promptly. There was evidence of action taken as a result for example the practice had changed the way in which they communicated test results to patients to ensure accurate information for all results was given.

National patient safety alerts were received by the practice manager and health care assistant via email. These were then checked for relevance to the practice. Information was then disseminated by internal messaging, staff and partners' meetings to relevant practice staff.

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. We asked staff about their most recent training. They 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.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had the necessary training to level three to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who accompanies another person during treatment or examination). Nursing staff or GPs acted as chaperones when required. However information available for patients and the practice policy on chaperones indicated that a chaperone could be a friend or relative.

Are services safe?

Staff told us that there were occasions when administration staff had been used as chaperones. The practice had ensured that all staff had been checked through the Disclosure and Barring Service (DBS) and had received training from the practice nurse about their responsibilities as a chaperone.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare which collated all communications about the patient including scanned copies of communications from hospitals.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the fridges. Staff we spoke with told us about the checks they made of fridge temperatures and were clear about the need to maintain the cold chain in relation to temperature sensitive medicines and vaccines. They could tell us the actions they would take if the cold chain had been broken. We saw that a backup thermometer was used to record fridge temperatures should there be a disruption to power. However these were not effective as they were placed too near the door so they did not accurately record the temperature of the medicines and were easily affected by the opening of the door. Emergency medicines for cardiac arrest and other medical emergencies were available, although they were not in a prominent position all staff knew their location. We noted that some of the equipment which may be needed in an emergency such as syringes and needles had exceeded their use by date. The emergency kits were not well organised and did not include a list of contents which could have caused delay in an emergency while staff located the appropriate emergency medicine.

When nurses administered prescription only medicines e.g. vaccines, Patient Group Directions or Patient Specific Directions were in place in line with relevant legislation.

Patients were able to request repeat prescriptions at the practice, by post, fax or online, patients told us they did not have any concerns about the process. The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. Staff explained how the repeat prescribing system was operated. For example, how staff generated prescriptions and monitored for over and under use and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Blank prescriptions were stored securely.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients 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 procedures at the practice. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff including those in administrative and reception roles had received training about infection control in March 2014. Infection prevention and control was a regular subject for refresher training at the practice's bi monthly training sessions. We saw evidence that the lead had carried out audits of the infection control procedures at the practice and that any improvements identified for action had been completed.

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. The practice had recently sought guidance from a variety of sources in relation to waste segregation. They had put in

place detailed guidance for staff to ensure waste was disposed of appropriately. Appropriate waste bins for infectious clinical waste were only available in treatment rooms. However we were told that in the event of this type of waste in consulting rooms there were appropriate bags available to transport the waste to the appropriate bin.

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 risk assessment carried out by a plumber to assess the possible risks posed by legionella (a bacterium found in the environment that can contaminate water systems in buildings). The risk assessment had identified that the practice building had no water storage system which represented a low risk to staff and patients. The practice did not have a plan to review their assessment to ensure it continued to reflect the level of risk.

Any occupational health issues for staff were met through a contract with a local health care trust. We noted that new staff were required to provide a vaccination history and other staff were reminded to attend for boosters through a message on the payroll system.

Equipment

Staff told us they had no concerns about the safety, suitability or availability of equipment. We saw that medical equipment had been calibrated in July 2014, there had been no action necessary at that time as all equipment was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) in January 2014 and were deemed safe to use.

Staffing and recruitment

There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave; the staff we spoke with told us they were happy with this arrangement. The practice also had a number of bank staff they could call on to cover absences in reception or administration The majority of staff had worked at the practice for a number of years, the practice manager and GPs told us they felt the stable work force provided a safe environment for their patients.

Patients did not report any difficulty in accessing a GP consultation. This was confirmed by reception staff who had not experienced difficulty meeting patients' needs for GP consultations. 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 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.

The practice manager 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 all staffing groups to ensure they were enough staff on duty. Reception staff told us they rotated tasks to include scanning and managing repeat prescriptions which meant that covering for each other was easier.

The practice manager audited the staff mix and hours against those of local practices. They were able to demonstrate that clinical and administration capacity was better than local practices per patient. We attended a practice meeting on the day of our inspection. Staffing levels were discussed including recent recruitment and proposed recruitment for a GP and receptionist were for increased hours to reflect the growing patient list size and times of increased demand on reception staff.

The staff recruitment policy showed that appropriate checks had been carried out on staff before starting work at the practice. The practice policy was that all staff had criminal records checks via the Disclosure and Barring Service (DBS). GPs and nursing staff had enhanced DBS checks.

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 criminal records checks via the DBS. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included maintenance of the building, the environment, staffing and emergency procedures. There was a health and safety policy and an identified health and safety representative. The practice's statement of general policy on health and safety was available for patients on their website.

Are services safe?

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice held regular multi-disciplinary meetings where patient needs were discussed. We saw that risks associated with service and staffing changes had been recognised and forward planning was in place to manage this. For example partners had discussed staffing levels and had started recruitment to take into account increased patient numbers during term time and when a nearby housing development was due to be completed.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. The practice had an automated external defibrillator (AED) which could be used in the emergency treatment of a person having a cardiac arrest. We were told that the emergency equipment, oxygen and emergency medicines were checked monthly by a practice nurse to ensure the equipment was working and the medicines were in date to ensure they would be safe to use should an emergency arise. However we found that these checks were not always effective as some syringes and needles had reached their use by date. The practice manager immediately arranged for these to be replaced and introduced a system whereby two people took responsibility for the checks to mitigate any future risk.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice had established relationships, and formal arrangements were in place, with neighbouring practices to ensure that patient care could continue in an emergency.

A fire risk assessment had been completed and we saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All GPs were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines had been discussed and the implications for the practice's performance and patient care. All partner and multidisciplinary meetings were minuted. Whilst there was no formal policy for ensuring GPs and nurses remained up-to-date the practice manager kept a log of all training in subjects such as infection control, child and adult protection and equality and diversity. All GPs were aware of their professional responsibilities to maintain their professional knowledge.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. Patients had their needs assessed and care planned in accordance to best practice. All new patients to the practice over the age of 40 were offered a health assessment carried out by the practice nurse to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. Patients new to the practice on repeat medications were required to book medication review before any prescriptions were issued. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients and for those patients whose GP was not available or on annual leave. Results could be communicated to patients by text message if requested.

The practice ran a number of specialised clinics to meet the needs of patients. These included a diabetic clinic where related health checks were carried out by practice nurses with specialised training in the disease GPs were kept informed of any concerns. The practice nurses also provided clinics for those patients with asthma and heart disease. The practice had taken part in a Cardio Vascular Disease (CVD) health check pilot programme where patients had been invited for a health check with trained healthcare assistants. The practice had identified that the number of patients taking up this assessment was poor. They had taken over the organisation of the invitations from Hampshire County Council's Public Health administrative team and as a result the number of CVD health checks had increased.

GPs and nurses were very open about asking for, and providing colleagues with, advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines. GPs provided support to colleagues through an end of morning meeting each day where areas of interest and clinical issues were shared. A record of these meetings was kept for reference and training purposes.

The practice referred patients appropriately to hospital and other community care services. National data showed the practice is in line with national standards on referral rates for all conditions. We saw evidence of appropriate use of two week wait referrals.

The practice was aware of those patients at risk of frequent hospital admission. Care plans had been produced for each of these patients. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We attended one of the practices multi-disciplinary meetings which was used to review patients recently discharged from hospital and those patients who required a multi-disciplinary approach to their complex health and social needs.

Interviews with GPs and staff showed that the culture in the practice was that patients were referred on need and decisions were not adversely influenced by patient age, gender or race.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. The practice undertook regular clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's performance. (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.)

The practice regularly reviewed their achievements against QOF. The practice had strong links with neighbouring practices who they worked with to identify best practice and improve outcomes for their patients. The QOF data was actively monitored at the practice and GPs were made

Are services effective?

(for example, treatment is effective)

aware of any shortfalls that needed to be addressed at quarterly meetings. Administration staff were responsible for tracking progress against QOF. QOF data showed the practice performed well in comparison to local practices.

The practice has a system in place for completing clinical audit cycles. We saw evidence of complete clinical audit cycles one of which showed the practice had assessed the risks and benefits of antibiotic prescribing for patients with acute tonsillitis. Also that the safe prescribing of medicines for diabetes had been reviewed and followed current best practice guidelines. Following the audit actions were agreed with the GPs, nurses and community diabetic service to review the medication needs of these patients and the findings of the audit had been discussed by the practice GPs. The practice had carried out other audits to improve patient care for example to audit the hospital attendance of their patients with the aim of identifying common themes in order to reduce the number of admissions. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in the previous 15 months was higher than the national average figure for England. As was those patients with diabetes who had received a test of their cholesterol level in the previous 15 months. The practice met all standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF clinical targets.

The practice made use of clinical audit tools, staff appraisal and staff meetings to assess the performance of nursing staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and lung disease. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

All staff in both clinical and administrative roles told us they were well supported by the GPs and the practice manager. There was a system of induction in place for newly recruited staff. All staff as part of their induction received the staff handbook which had been regularly reviewed to ensure it contained relevant up to date guidance. Each new member of staff was paired with a mentor who provided help and support and oversaw the employee's development.

There was an annual appraisal system in place for staff. Staff confirmed they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. Staff told us the practice organised staff training in a number of subjects and supported staff to attend relevant training. The practice arranged a training session for all staff every two months. Each week there was an hour put aside for role specific training for example GP to GP training or IT updates. All practice staff had received training in basic life support, information governance and child and adult protection. GPs took part in a peer review appraisal; these appraisals formed part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of their appraisal schedule and revalidation dates. (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). GPs were supported by their colleagues to complete the appraisal and revalidation process.

During our inspection we spoke with nine patients, reviewed 12 comment cards and spoke with five representatives of the patient reference group. They all commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice. There was sufficient staff available to meet their needs.

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 on the day they

Are services effective?

(for example, treatment is effective)

were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held weekly multidisciplinary team meetings to discuss the needs of complex patients e.g. those with end of life care needs, children on the at risk register or recent hospital discharges. These meetings were attended by district nurses, social workers, palliative care nurses and the community pharmacist decisions about care planning were documented in a shared care record. We attended a multi-disciplinary meeting on the day of our inspection. This meeting was attended by the GPs and representatives from the wider health care team to discuss specific concerns to ensure the best treatment outcomes for patients. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice premises to provide services to patients. These included a counsellor, the community nursing team, smoking cessation services and the local health care trust.

There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results, received from other health care providers, for their patients and for those patients whose GP was not available or on annual leave. The GP seeing these documents and results was responsible for the action required.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system if required. (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).

Patient information was stored securely on the practice's electronic record system. Patient records could be accessed by appropriate staff in order to plan and deliver patient 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 practice had historic paper patient records which were used if necessary to review medical histories. The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs we spoke with understood the key parts of the legislation in relation to Mental Capacity Act 2005 (MCA). They were clear about their responsibilities when patients did not have capacity for decision making. However not all nursing staff understood the MCA and when it would be used. GPs had access to a mental capacity toolkit but not all GPs and nursing staff had received specific training in the subject. Patients with learning disabilities and those with dementia were supported to make decisions usually with their families or carers.

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged under 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment.

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgery and some family planning procedures. For other interventions a patient's verbal consent was documented in the electronic patient notes.

Health promotion and prevention

All new patients to the practice over 40 years of age and those with repeat medication were offered a health assessment to ensure the practice was aware of their health needs. These were carried out by the practice nurses who would discuss the findings with patients and refer to a GP if a medical opinion or diagnosis was required.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations

Are services effective?

(for example, treatment is effective)

such as bereavement support. The practice leaflet was available at the practice and was also available on their website. The practice leaflet gave some self-treatment suggestions for common illnesses and accidents.

Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. The practice offered a full travel vaccination service and is one of the yellow fever centres in the CCG area. This enabled nurses to advise patients about the management of their own health in these specialist areas.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. Travel vaccines and flu vaccinations were also available and administered in line with current national guidance. Data showed that last year's performance for patients over 65 who received the seasonal flu vaccination was above average for the CCG.

The practice had a number of ways of identifying patients who needed support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and those with diabetes and these patients were offered an annual physical health check .The practice was able to offer in house smoking cessation clinics provided by the local health care trust. Similar mechanisms of identifying at risk groups were used for patients who were carers and those receiving end of life care. These groups were offered further support in line with their needs.

The practice promoted chlamydia screening for young people and those in the at risk age range were offered a self-test when they visited the practice. The practice had audited the number of completed tests to assess the effectiveness of their campaign.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with nine patients, reviewed 12 comment cards and spoke with five representatives of the patient reference group (PRG). Almost everybody was complementary about the care that they, or the patients they represented, received from all the practice staff. We spoke with patients of varying ages who said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included their own satisfaction survey, information from the NHS England GP patient survey and NHS Choices. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect.

Staff told us how they respected patients' confidentiality and privacy. All telephone calls were answered by staff in a closed office behind the reception desk and ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. However there were instances when patient details could be heard when patients approached the reception desk to book in or make an appointment. There was a private area available for patients beside the reception area where private conversations could take place. All staff had taken part in information governance training and those we asked were able to demonstrate how they ensured patients privacy and confidentiality was maintained.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the practice's satisfaction survey showed 93% of practice respondents said the GP or nurse they last saw was helpful or extremely helpful in explaining their medical condition, with 96 % commenting positively on the way the GP or nurse listened to them.

Patients told us that their GP explained their treatment and that there was enough time to discuss their needs. Apart from one patient, they also told us they felt listened to and supported by staff who ensured they understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the informative, approachable, caring and supportive attitude of the GPs and nurses.

Staff told us that translation services were available for patients who did not have English as a first language this information was also available in the practice booklet.

Patient/carer support to cope emotionally with care and treatment

On the day of our inspection we attended the practice's weekly multi-disciplinary meeting. GPs discussed bereaved families and the support they may need. One GP had telephoned a recently bereaved family to offer help and support and a visit if required. Other patients were discussed including the emotional and practical support that their carer may need. For example a carer who had difficulty with moving and handling was to be referred to the occupational health team to provide advice and support.

The electronic record system was updated with details of patients' caring responsibilities. New patient registration forms asked if a prospective patient was a carer or had a carer. A recent practice newsletter had been used to try and identify carers amongst the practice population, in order to make them aware of the support available. Flu vaccinations were available to all those with caring responsibilities.

GPs told us that they involved families and carers in end of life care. The practice ensured the out of hours service received specific patient health records. This included individualised information about patients' complex health, social care or end of life needs.

One of the patients who provided feedback told us of the emotional support that one of the GPs had provided to them during a difficult diagnosis and had provided practical and emotional support to their family.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

All patients had a named GP who was responsible for their care. Patients told us they accepted that if they required an emergency appointment they saw the first GP who was available. All patients over 75 had a named GP in line with current recommendations. GPs continued to provide care for their own patients if they went to live in one of the local care homes. Longer appointments were available for people who needed them such as those with long term conditions or a learning disability. Home visits were made to those who needed them and to 11 local care homes where patients were visited by their own named GP whenever possible. There had been very little turnover of staff over recent years which enabled good continuity of care and accessibility to appointments with a GP of choice.

The practice staff were aware of the practice population in respect of age, ethnic origin and number of patients with long term conditions and had responded to the needs of the practice population. The practice had a high percentage of patients of working age and provided GP services to a large number of students from Winchester University. The practice took part in the Meningococcal (Men C) fresher's vaccination programme to protect their student patients from Meningitis. Other services such as contraception services and clamydia screening were actively promoted by GPs and nurses to the students and young people.

Early morning appointments and Saturday morning surgery was available for patients who could not attend during weekdays due to work commitments. The practice had identified that there had been an increase in afternoon telephone calls. The practice was actively recruiting for staff to work at those times.

The practice engaged regularly with the West Hampshire Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was one of 19 local practices who had joined together as a federation to discuss best practice and to work together to improve outcomes and services for their patients. The practice was conducting a pilot programme of cardio vascular disease (CVD) health checks.

The practice had a patient reference group (PRG) of approximately 300 patients. The group had been consulted about the questions for the annual patient survey carried out between December 2013 and January 2014. Following the survey the PRG had agreed a plan of action with the practice for changes in response to the outcome of the survey. For example a system to alert patients if their GP was running late and the appointment of a new partner who was able to work more sessions per week to provide more GP appointments.

We spoke with five members of the PRG who were keen to promote and compliment the responsiveness of the practice. They explained how they worked with the practice for the benefit of patients. They said that the practice responded to any feedback they gave and that continual improvements to the systems at the practice had taken place.

The practice had a large number of patients with diabetes and had introduced a system to ensure they were all seen on a regular basis to monitor their condition and to provide advice and education. A phlebotomist (a person who has been trained to take blood samples) from the local general hospital saw patients at the practice two days a week to take blood samples for patients. This service meant patients did not have to travel to the hospital for any diagnostic blood tests. This service had been implemented following patient feedback from the practice's 2012-2013 survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example those with a learning disability, the elderly living in care homes, children under-five, patients who had work commitments, and those with long term conditions.

The practice had a number of older patients who lived in local care homes. If these patients required a GP they were visited in their care home by their own GP. The GPs used these visits to speak with or monitor the health of any other of their patients who lived in the same home.

The majority of staff had undertaken training in equality and diversity and could demonstrate that they promoted equality in the practice in most situations.

The premises were purpose built and had been designed to meet the needs of people with disabilities. The premises were accessible to patients who used wheelchairs. There

Are services responsive to people's needs?

(for example, to feedback?)

was a lift that provided access to the first floor. The practice had facilities for patients with a disability and an area of the reception desk was at a lower level for patients who may use a wheelchair. A seat was provided in this area for those patients who may need to sit down to complete paperwork. There was a hearing loop to assist patients with hearing difficulties. The practice was able to organise telephone or face to face interpretation services for patients whose first language was not English. The main doors to the building did not operate automatically which made entering the building difficult for people with mobility issues and families with pushchairs or prams. However we saw that there was a bell for patients to summon assistance. We noted that there were no arrangements for the disposal of sanitary waste in the wheelchair accessible toilets; this did not promote equality or dignity for these patients.

Access to the service

The practice had a high percentage of patients of working age and provided GP services to a large number of students from Winchester University. Early morning appointments and Saturday morning surgery was available for patients who could not attend during weekdays due to work commitments. The practice had identified that there had been an increase in afternoon telephone calls. The practice was actively recruiting for staff to work at those times.

Information relating to the practice opening hours was available on the practice website and in the practice leaflet. These gave information for patients on how they could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them. Opening hours were from 8 am to 6.30 pm Thursday and Friday and until 7.30 pm Monday to Wednesday with appointments available every other Saturday between 8 am and 10 am.

Patients told us they had not encountered any problems making appointments when they needed them. They told us that they were able to get emergency appointments on the day they needed but sometimes had to wait a few days to get a routine appointment or to see the GP of their choice. Patients had a named GP but those we spoke with said they could see the GP of their choice and understood that for an urgent appointment they would see the first available GP. We spoke with nine patients, five representatives of the PRG, looked at feedback that had been left on NHS choices and reviewed 12 comment cards. Most patients felt that they could access a GP when they needed to. The patients we spoke with were clear about how the practice operated their appointment system.

Reception staff explained the appointment booking system. Patients could telephone the practice or book routine appointments on line. Telephone consultations were also available to enable patients to speak with a GP. Clear details of the appointment system were available in the practice leaflet and on the practice website. The practice had a duty doctor available every day and nurse triage to ensure that any patient who felt they need to see a GP could do so.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out of hours service. 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. Information about the out of hours service was also provided to patients in the practice leaflet and on the website.

The practice manager carried out a weekly audit on appointment availability which showed the practice monitored their own performance in relation to responding quickly to patients' needs. The practice had plans in place to increase consulting room space and GP consulting sessions in order to anticipate increased demand with an aspiration that no patient would have to wait longer than 5 days to access a routine GP appointment.

Listening and learning from concerns and complaints

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

Information was provided to help patients understand the complaints system this was set out in the practice complaints leaflet and on the practice website however details of how to make complaints were not included in the practice booklet. Patients were asked to put formal

Are services responsive to people's needs?

(for example, to feedback?)

complaints in writing and forms were available at reception for patients to complete. There was no available information about verbal complaints or how people could be supported if they wanted to make a complaint.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. The record of complaints showed that all complaints had been responded to in a courteous manner by the practice manager. Some of the comments made about the practice on the NHS Choices website had been responded to by the practice manager, either thanking the patient for their positive comments, or encouraging the patient to approach the practice to allow them to address their concerns. The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback.

The practice reviewed complaints on a regular basis to detect themes or trends. We looked at the report for the last review and no themes had been identified.

Are services well-led?

(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 improve the health, well-being and lives of those they cared for. To work in partnership with their patients and staff to provide the best primary care services possible working within local and national governance, guidance and regulations. Their practice ethos was that patient care came first above all other needs of the practice. The practice's mission statement and vision were displayed on their website.

We spoke with the GPs working at the practice on the day of our inspection, one of the practice nurses, the practice manager and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these. All staff felt able to make suggestions to improve outcomes for patients for example in relation to appointment systems or from personal research or learning. GP and nursing staff used weekly meetings, daily end of morning discussion, and clinical audit to share and discuss information to improve effective patient care.

The practice worked with other practices towards providing improved services for their patients. Patients described the practice as caring, supportive and friendly.

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 a large number of these policies and procedures and most staff were aware of their availability however there was no evidence that staff had read those relevant to their role. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice held an annual meeting where governance issues were discussed; additionally clinical governance was a regular topic for discussion at weekly partners' meetings. We attended a meeting and looked at minutes from meetings. We found that performance, quality and risks were discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at GP meetings. The practice manager was aware of how the practice was performing in relation to their targets, action plans were produced to maintain or improve outcomes. The practice had taken part in a pilot programme for providing cardio vascular disease (CVD) health checks. They had audited this programme and had identified the uptake of these checks was poor. They had taken over the organisation of the invitations from Hampshire County Council's Public Health administrative team and as a result the number of CVD health checks had increased.

The practice had completed a number of clinical audits, for example in prescribing for acute tonsillitis and care of the diabetic patient. There was a weekly audit of appointments with a constant review of staffing levels. The staff mix and hours had been analysed against other local practices and any adjustments made. The practice had invested in IT training and additional IT systems to improve efficiency.

The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

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 one of the partners was the lead safeguarding and another was the practice's Caldecott Guardian. The weekly partners' meetings were used for GPs to cascade information to colleagues. The GPs all felt they had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice through audits or specialist training. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing staff whose roles were in reception or administration.

The leadership was established at the practice as GP partners had been in their roles for a number of years. The practice manager was highly respected by all the staff we spoke with who told us they felt supported by the practice manager and GPs. They confirmed there was an open culture and felt that they could go to any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training. The practice held bi-monthly staff meetings

Are services well-led?

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

where staff were informed of any changes and staff were able to make any suggestions to improve the practice. Appraisals were carried out annually and training was supported by the GP partners and practice management. The bi-monthly staff meetings alternated with bi-monthly staff training. There was time set aside weekly for role specific training.

We saw that serious events were reported and discussed at weekly GP meetings for discussion and not to apportion blame. Staff informed us that communication within teams and across the practice was good with information shared appropriately.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example equal opportunities policy, health and safety, grievance and disciplinary procedure, which were in place to support staff. We were shown a copy of the staff induction procedure that was in place for all new staff. The practice manager spent time with new employees who were also supported by a mentor and were given a staff handbook which included operational procedures and protocols.

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

The practice had gathered feedback from patients through a survey carried out with the patient reference group (PRG), the NHS Choices website, the national GP survey and patient compliments and complaints. The practice manager had asked for feedback from all staff about the practice, their role, suggestions for improvements to the practice, how well trained they felt for their role, suggestions for efficiency and what they expected of them as practice manager.

We looked at the results of the most recent patient survey conducted by the practice and the subsequent action plan. The action plan had also been sent to members of the PRG for comment and further suggestions. The results and actions agreed from these surveys were available on the practice website. The practice manager was able to confirm that the practice had completed all actions to improve the practice following this patient feedback. For example the practice had purchased and installed software for their check-in screen to let patients to know if their doctor or nurse was running late, and by how long. Receptionists were also able to give patients this information. All staff including GPs and nurses had taken part in training to improve customer care as there had been some feedback regarding the interpersonal skills of some staff. The practice had committed to increasing GP access and had increased the number of GP sessions twice since the survey to a total of six more GP sessions per week.

The practice had a large and active PRG which has steadily increased in size. The PRG contained representatives from various age ranges and population groups. The practice had identified one group of patients that were not represented by the PRG invitation process, namely those patients resident in nursing or residential care homes. In order to allow them to participate in the PRG the practice had telephoned every care home where patients of St. Paul's were resident and asked if members of staff would canvas patient's views. They reported that 14 contacts were added to the PRG and a survey allowing general feedback as well as 'areas of interest' had been sent to each contact.

The practice had gathered feedback from staff through a staff survey 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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 saw that regular appraisals took place and all staff we spoke with confirmed they had taken part in the appraisal process. Staff told us that the practice was very supportive of training and provided regular bi monthly and weekly training.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients. All staff were able to contribute to staff meetings and to make suggestions for future training.