Dr Peter Linn

Quality Report

Angel Lane Surgery
Angel Lane
Great Dunmow
Essex CM6 1AQ
Tel: 01371 872122
Website: www.angellanesurgery.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Peter Linn (also known as Angel Lane Surgery) on 8 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the 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, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

The provider should

Summary of findings

- Conduct risk assessments for staff who undertake chaperone duties
- Improve patient recall arrangements to ensure patients' needs are identified and met e.g. relating to diabetic patient checks
- Enhance staff understanding of adult safeguarding
- Ensure the business continuity plan provides sufficient detail on how services would be delivered in the event of an interruption of services and how this would be communicated to patients.
- Conduct joint clinical meetings for GPs and the nursing team to share knowledge and promote good practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. However, the practice did not adhere to their own safeguarding policy requiring all staff to undertaken criminal record checks. Neither criminal record checks or risk assessments had been conducted for administrative staff who undertook chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to improve outcomes for patients and ensure coordinated care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population providing care to patients with dementia and receiving end of life care. It was responsive to the needs of older people, with an emergency phone number for professionals to access the clinical team for advice. The practice offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of unplanned hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, we found inconsistent recall of diabetic patients; this was acknowledged, at the time of our inspection, by the practice as an area for improvement.

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. For example, patient appointments could be booked outside normal opening hours on their phone system. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It invited people with a learning disability for annual health checks and followed up on non-attendance. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients experiencing poor mental health and all patients were invited for an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisation. Staff had not received training on how to care for people with mental health needs and/or dementia, but showed sensitivity when addressing their individual needs.

Summary of findings

What people who use the service say

We reviewed the findings of the National Patient Survey 2014 for which there were 131 responses from the 268 questionnaires distributed to patients, a response rate of 49% of those people contacted. The practice performed above average within their Clinical Commissioning Group in relation to; patients being given enough time when they saw or spoke to the last GP they saw, the GP was good at listening to them and the last appointment they got being convenient. However, the practice performed just below the Clinical Commissioning Group average for; patients getting to see or speak with their preferred GP, for the nurse being good at explaining tests and treatments and for patients recommending the practice.

We reviewed patient comments on the NHS choices website. Seven entries had been made between 22 January and 13 January 2015. Four out of the seven comments rated the practice as five out of five for providing an excellent service. However, the comments did include reference to some difficulties; for example, difficulties were experienced for patients obtaining blood tests since the phlebotomy service no longer operated from the practice, patients receiving a poor telephone service and concerns relating to the conduct of dispensary staff. The practice had responded to the concerns and explained the change of funding in respect of the phlebotomy service. However, during our inspection we were informed that the phlebotomy service was being reintroduced.

We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we may capture their experiences of the service. We received 19 completed Care Quality Commission comment cards. These were positive about the care patients received. Patients told us staff were friendly, polite and helpful to them. They had confidence in the clinical team and were happy to see them for assessment and treatment.

We spoke with two patients in attendance at the practice on the day of our inspection. They all told us how friendly, supportive and caring they found both the clinical and administrative team.

We spoke with partner health and social care services such as the District Nursing Team and care homes for the elderly and people with dementia. They all reported receiving a good service from the practice. They told us they had confidence in all staff who were described as responsive to patients needs and always good at sharing information appropriately, honouring requests for home visits, working in partnership to develop personalised care plans to meet the patients individual needs.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Conduct risk assessments for staff who undertake chaperone duties
- Improve patient recall arrangements to ensure patients' needs are identified and met e.g. relating to diabetic patient checks
- Enhance staff understanding of adult safeguarding
- Ensure the business continuity plan provides sufficient detail on how services would be delivered during the interruption of services and how this would be communicated to patients.
- Conduct joint clinical meetings for GPs and the nursing team to share knowledge and promote good practice.

Dr Peter Linn

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Peter Linn

The practice service is located in a semi-rural market town serving neighbouring communities such as Felsted, High Easter, Stebbing and Little Easton. It has a patient population of approximately 9,521 having recently experienced an increase in numbers from 9,200 patients. The practice employs 26 staff with six GPS (three male and three female GPs) and Registrars. A GP Registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. They will usually have spent at least two years working in a hospital before you see them in a practice and are closely supervised by a senior GP or trainer. The practice has a practice nursing team including specialists in diabetes, smoking cessation, respiration and infection control. The practice is a teaching practice aligned to the East England Deanery and also has a dispensary and dispenses medication to approximately half of their patient group an estimated 5,100 patients.

The practice holds a General Medical Service contract. This is the type of contract the practice holds with NHS England to provide medical care to patients.

The practice has a comprehensive website providing a wealth of information for patients to understand and access services, including useful links to specialist support services.

The practice has opted out of providing out-of-hours services to their own patients. Emergency medical attention between 6:30pm and 8am weekends and bank holidays is provided by contacting the NHS 111 service in the first instance.

Why we carried out this inspection

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

Comprehensive inspections are conducted 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit 8 April 2015. During our visit we spoke with a range of staff, practice manager, GPs, reception and administrators and members of the nursing team and spoke with patients who used the service. We talked with carers and/or family members and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, and incident reports.

National patient safety alerts were disseminated by the practice manager to the practice staff including dispensary staff. Where concerns related to medicines, searches were conducted of patient records to identify those who may be adversely affected and then necessary medication reviews prompted. The practice either called the patient or would write to the patient if an immediate response of recall of medication was required.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 2 years and we were able to review these. We reviewed the significant events meetings minutes for 24 June 2014 and 5 February 2015. We found the minute minutes were not an accurate reflection of actions taken by the practice. The practice told us all incidents were discussed and immediately actions taken at the time of reporting. However, no record was maintained of these discussions, only the formal discussions where events were discussed and reviewed six monthly.

Learning and improvement from safety incidents

We looked at systems in place from learning and improving following receipt of safety incidents. We found two incidents recorded of children injuring their hands in the newly installed sliding entrance doors in February 2015. The practice had recorded these within their accident book. The practice had spoken with the door manufacturers and commissioned safety alterations to the door to mitigate the risk of further children being injured. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

We tracked two significant incidents reported between June 2014 and February 2015. We saw records were incomplete with no review dates given of sign off as complete by a senior partner or the practice manager. For example, we reviewed an incident alleging an inappropriate clinical referral from the practice dated 12 August 2014. This was discussed during the February 2015 practice meeting, six months later. The notes identified persons involved in the alleged incident, actions to be taken. However, the records did not identify persons responsible for undertaking follow up actions, when and how this were to be conducted and how the practice would mitigate the risk occurring in the future. We reviewed another incident relating to a patient receiving a needle stick injury, again this was discussed two months after the incident during the February 2015 meeting and the minutes failed to detail the person responsible for conducting follow up actions such as disseminating learning and ensuring changes were implemented.

Reliable safety systems and processes including safeguarding

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

The practice had an appointed dedicated GP lead in safeguarding children but not in safeguarding vulnerable adults. The practice did not have a policy or minimum training requirement of non-medical or administrative staff in adult safeguarding. Given the practice's aging patient population and providing care for vulnerable patients with dementia this is an area they acknowledge improvement should be made. However, all the GP's had been trained to level 3 in child safeguarding, the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. The practice maintained registers of children subject to child protection plans and those looked after by the local authority. These were

regularly checked to ensure accuracy. Patient information was updated and included information to make staff aware of any relevant issues when patients attended appointments; for example children who routinely missed appointments. We reviewed minutes of the child protection meetings and saw the needs of the child were discussed with service involved in delivering care and support to them and their families.

There was a chaperone policy, and the service was advertised and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, had been trained and undertaken the relevant security checks to be a chaperone. However, reception staff would act as a chaperone if nursing staff were not available. Reception staff had not received formal training but had an understanding of their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. None of the reception staff had undertaken a criminal record check.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to adults, 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 records demonstrated good liaison with partner agencies such as the police and social services. The practice followed up on children who persistently failed to attend appointments e.g. for childhood immunisations. Letters were sent to the patients / patient's guardian where there was repeat, non-attendance and partner agencies such as health visitors spoken with where appropriate.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We reviewed the GP prescribing pad log which detailed the issuing of the pads and the name of the GP taking receipt.

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 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.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Records showed that all members of staff involved in the dispensing process had received appropriate training.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had

systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. However, these failed to provide sufficient assurance to the provider of when certain cleaning tasks had been conducted such as the cleaning of the communal toilets. The practice manager had been actively addressing the need for greater transparency and assurance regarding cleaning undertaken. However, patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an infection prevention control audit for the last year, dated 2 April 2015. The audit was supported by an action plan detailing corrective action to be taken, who was responsible and date to be completed by.

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

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

The practice had arranged for the management, testing and investigation of legionella on 18 April 2015. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer on 2 July 2014.

Staffing and recruitment

Staff 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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff, and required a minimum of a DBS check, two references and an interview held face to face as detailed under the practice safeguarding policy. All staff received induction information, explaining their role, responsibilities, rights and entitlements.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager shared her role with the deputy practice manager. Both staff members were aware of their remits and we saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice had acknowledged the need for a healthcare assistant to support the clinical team especially with phlebotomy duties, now being delivered to patients under the practice under a new contract.

Good

Are services safe?

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 checks of the building, equipment, the environment, medicines management, staffing, and dealing with emergencies. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. The practice was considering appointing a health and safety representative.

The practice manager led on risk assessments. Every room had a risk log displayed to supplement overarching risk strategies for issues such as, fire and infection control. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The risk logs were revised annually or as circumstances changed.

Arrangements to deal with emergencies and major incidents

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

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. There was insufficient detail of how the practice intended to mitigate the risks of the incidents occurring. Risks identified included power failure, adverse weather, unplanned sickness and access to the building and the document contained relevant contact details for staff to refer to. However, it lacked detail on how services would be delivered during the interruption of services and how this would be communicated to patients.

The practice had conducted a fire risk assessment dated 15 January 2015, The practice had appointed three fire wardens trained in evacuation and records showed that staff had conducted regular monthly call point testing. Fire extinguisher training for staff was proposed for the future. Essex County Fire and Rescue Service had attended the practice on 15 October 2014 and confirmed the practice had met a satisfactory standard of fire safety.

Risks associated with the service and staffing changes (both planned and unplanned) were understood and known by the management. Most staff worked part time especially within the dispensary and reception and this provided the practice with flexibility and additional potential capacity during staff absences. Staff told us they were often able and willing to cover for colleagues.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

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

The GPs told us they led in specialist clinical areas such as ophthalmology, diabetes, minor surgery, sexual health, palliative care and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the practice meeting minutes confirmed that this happened.

We reviewed the practice's performance for antibiotic prescribing, which was slightly higher than comparable to similar practices. We discussed this with the GPs and reviewed their clinical audit which suggested appropriate clinical practice.

National data showed that the practice was in line with referral rates to secondary 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. The practice actively checked to ensure this was conducted.

Discrimination was avoided when making care and treatment decisions. Our interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, with clinicians taking lead areas and ownership of their respective specialisms such as respiratory disorders. The practice manager had found this had been effective for improving performance and outcomes for people. 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 three clinical audits that had been undertaken in the last two years. One of audits related to proton pump inhibitors (PPIs), used for treating symptoms of ulcers and heartburn (dyspepsia) by reducing stomach acid, and non-steroidal anti-inflammatory drugs (NSAIDS) and the practice identified that they had met guidance in relation to 65% of their applicable patients. This was discussed during a practice meeting and the repeat audit found an increase of patients receiving appropriate care at 87%.

The second audit was conducted on patient notes, where tasks had been passed by computer between staff relating to the care of patients. It was not a clinical audit, rather administrative to determine if they were all appropriate and necessary. The repeat audit showed no change in the volume of notifications, but the clinicians felt the notification were more appropriate.

The third audit related to the treatment of urinary tract infections in non-pregnant women. The audit cycle was incomplete but had been commenced by the GP registrar. The original audit showed reasonable practice in that most prescriptions were appropriate for first line antibiotics. The audit had not yet been presented to the GPs to enable an action plan to be formulated.

The programmes to monitor outcomes for patients practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventing measures. The results are published annually. For example, information we held about the practice suggested they had lower than national average

Good

Are services effective?

(for example, treatment is effective)

performance on a range of routine diabetes monitoring checks. We spoke to the practice regarding these findings. They told us, they had recognised the issue and discussed their recall policy for patients with diabetes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where these could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a process for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice had increased the use of dosette boxes assisting people to self-manage medication. They also managed a system for patients on regular medication for whom the ordering of medication was difficult. This had been well received by patients.

The practice had implemented the Gold Standards Framework (GSF) for end of life care. GSF is intended to improve the quality, coordination and organisation of care leading to better patient outcomes in line with their needs and preferences and greater cost efficiency through reducing hospitalisation. The practice had a palliative care register and also held regular monthly internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice compared themselves against other similar practices for prescribing data and referral data. The practice had identified disparities between clinician prescribing and referral practices, which were being addressed through education and peer review to deliver more consistent care and treatment.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with strengths in specialist interests and experience in secondary care. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the dispensers had undertaken appropriate training in safe dispensing and the use of dispensing equipment. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments to see their patients and were assigned to senior GP's throughout the day for support. We received positive feedback from the trainees we spoke with regarding the accessibility and support they received from staff.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles in asthma and diabetes care were also able to demonstrate that they had appropriate training to fulfil these roles such as undertaking the certificate of diabetes care course from the University of Warwick.

The practice manager had no reported incidents of poor performance by staff. However, the practice staff induction pack detailed the rights and entitlements of staff and the capability procedures should staff be unable or experience difficulties undertaking their role. The practice manager told us, should such an incident occur the practice would initially try to support the staff member through training and development.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service summaries both electronically and by post. The practice had outlining responsibilities for all relevant staff in passing

Good

Are services effective?

(for example, treatment is effective)

on, reading and acting on any issues arising from communications with other care providers on the day they were received. The named GPs reviewed these documents and results, and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital if they were on the unplanned admissions list. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice also reviewed all the patients who were unplanned admissions from care homes.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs., for example those with end of life care needs or children on the at risk register. These meetings were attended by the community matron, district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. 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, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, at the request of the patient the practice provided a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

We spoke to the District Nursing Team who spoke highly of how the practice responded to and shared information to meet the needs of patients. For example, the practice had embraced the enhanced care project to address the needs of frail patients. The practice worked closely with health professionals, patients, their families and carers to develop individualised care plans reviewed monthly.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and included a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. This was supported by care homes professionals we spoke with. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions, with an emphasis on written consent. For example, we reviewed five patient consent forms for minor surgery and found all were appropriately endorsed and explained the relevant risks, benefits and potential complications of the procedure. Health professionals and caring professionals we spoke to told us how the GPs were supportive, sensitive and engaging with patients, families and carers to obtain vulnerable patients consent such as those patients with dementia.

Good

Are services effective?

(for example, treatment is effective)

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurses to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The checks had not been actively promoted through writing to patients, as the practice was trying to appoint a healthcare assistant to lead on these. However, the practice had numerous ways of identifying patients who needed additional support. For example the practice maintained registers of vulnerable groups such as people who experience poor mental health, people with learning disabilities, looked after children, children under child protection and those in receipt of palliative care. However, in some cases the registers were not actively utilised to monitor best practice. For example, the register of patients with a learning disability was not used to actively promote health checks and the child register was not used to monitor immunisation rates for children who were identified as vulnerable.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

All patients over 75 years had a named GP and we reviewed care planning meeting minutes and unplanned admission meeting minutes. The October 2014 meeting minutes stated that the practice had completed 151 care plans, 2% of the patient list and these were being reviewed monthly in addition to follow up calls to patients discharged from hospital. All the minutes reviewed showed evidence of co-ordinated and planned care including promoting the adoption of summary care records and partnership working with the District Nursing Team, Community Matron and End of Life Co-ordination Team.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the findings of the National Patient Survey 2014 for which there were 131 responses from the 268 questionnaires distributed to patients, a response rate of 49% for those people contacted. The practice performed above average within their Clinical Commissioning Group in relation to patients; being given enough time when they saw or spoke to the last GP they saw, for the GP beings good at listening to them and for their last appointment being convenient. However, the practice performed just below the Clinical Commissioning Group average for; patients getting to see or speak with their preferred GP, for the nurse being good at explaining tests and treatments and for patients recommending the practice.

We reviewed patient comments on the NHS choices website. Seven entries had been made between 22 January and 13 January 2015. Four out of the seven comments rating the practice as five out of five for providing an excellent service. However, the comments did include reference to some patients experiencing difficulties obtaining blood tests since the phlebotomy service no longer operated from the practice, patients receiving a poor telephone service and concerns raised relating to the conduct of dispensary staff. The practice had responded to the concerns and explained the change of funding in respect of the phlebotomy service. However, this service was recently reintroduced and the practice was seeking to appoint to the role.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and they were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive, remarking on being unable to book non-emergency appointments in advance and therefore being required to call on the morning, presenting difficulties as the patient had school age children. We spoke to the practice who informed us that appointments could be booked five to six weeks in advance and were also available on the day.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception staff were mindful of how exposed the reception area was and patients may be overheard. Notices were displayed advising patients that they may speak with staff privately and patients were asked to stand back from the desk, allowing one patient to approach at a time and thereby mitigating the risks of patients overhearing potentially private conversations.

Staff told us that 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 she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that they rarely experienced difficulties with patients being rude to them but felt supported by the practice manager should such situations arise.

Care planning and involvement in decisions about care and treatment

The 2014 Practice 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, 86% of the patients asked said the last nurse they saw or spoke to was good at involving them in decisions about their care. The results from the practice's own satisfaction survey showed that the majority of the patients who responded to their survey thought their GP was good or excellent at asking about their symptoms, asking how they felt and involving them with decisions.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

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. The reception staff had access to face to face and language line interpreters. However, the practice did not report a current need for the service.

Patient/carer support to cope emotionally with care and treatment

The 2014 National 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, 91% said the last nurse they saw or spoke to was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice survey had identified that the majority of the people asked had not looked at the practice website but a large proportion wanted to gain further information. In discussion with the Patient Participation Group (PPG) the practice has promoted the website; it also provided a wealth of information and advice for people on health and wellbeing such as counselling services and how and where these may be accessed. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care

Carers were identified at point of registration, and if later by staff when disclosures are made. Staff provided information and guidance to patients. The practice's computer system alerted GPs if a patient was also a carer.

The practice told us there were no defined process for the supporting bereaved patients and carers. However, where families had suffered a bereavement, their usual GP contacted them. The GP may offer them a patient consultation at a flexible time and location to meet the family's needs and/or give them advice on how to find a support service. The practice spoke with community groups to enhance their understanding of the needs of carers and disseminate important information to staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, where the practice had discussed patients' needs and how to best meet them in order to reduce the number of accident and emergency admissions.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care We reviewed the PPG meeting minutes for November 2014, January 2015 and March 2015. All were clearly documented, including key discussion points, actions allocated and persons responsible. For example, the PPG had discussed methods of raising the profile and voice of patients such as through the patient questionnaire and representation at CCG meetings. Progress was reviewed in relation to the publication of a patient newsletter and the building of a patient mobility scooter shelter. The group also reported on the appointment of new staff and any other concerns such as refurbishment of the toilet and accidents which had occurred on the premises.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice provided phlebotomy services to vulnerable patients and those over 70 years of age. This was also to be increased in acknowledgement of the rural communities they served and the difficulties patients reported in accessing appropriate and affordable public transportation to take them to neighbouring hospitals and community health facilities.

The practice had access to online and telephone translation services. They told us there was little demand for the service but acknowledged this may change with more people moving to the area.

The practice staff had not undertaken equality and diversity training. Staff we spoke with and saw speaking with patients were polite, patient and helpful in trying to resolve their needs in a timely and sensitive manner.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice occupied a purpose built premises constructed in1986. The practice was situated on the ground floors of the building. The practice had installed electronic sliding entrance doors and were considering additional alterations to promote patient independence. We found the practice corridors were not sufficiently wide enough for patients with mobility scooters to move throughout the practice freely. However, at the time of our inspection the practice did not have any patients with such a need. The practice told us they would regularly reassess the accessibility of service to patients and had offered and would provide additional practical assistance to patients, where required. .

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

Access to the service

The practice was open from 8am to 6.30pm and appointments were available from 9am to 11am and 3.30pm to 5.30pm on weekdays. The practice offered 842 appointments each week exceeding the patient appointment availability proposed by NHS England. Appointments could be booked five to six weeks in advance. The practice was intending to operate extended opening hours to 8pm due to additional funding from the Prime Minister's Challenge Fund Project. This was believed to be particularly useful to patients with work commitments and those who commuted to London, particularly.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a GP and more frequently where needed.

Patients were generally satisfied with the appointments system. They confirmed that they could often see a GP on the same day if they needed. Although they were often inclined to attend in person to make the appointment due to experiencing delays in the telephone system. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Healthcare professionals told us the practice had a dedicated emergency care line through to the practice to access clinical services and advice. On the day of our inspection, the district nurse called the line and it was immediately answered and appropriately actioned by the reception staff.

Home visits were available where needed, as were longer appointments. Children and young people were offered appointments outside of school hours, where available and priority was given to children under 16 years. The practice told us that their working age patients had welcomed the availability of their online booking system to providing convenience and flexibility.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager 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 on the patient complaint forms, reception notice board and on the waiting room notice board. Patients we spoke with were not aware of the process to follow if they wished to make a complaint but were happy to approach staff.

We found 12 complaints had been reported within the last 12 months. There was inconsistency in the management of complaints with an absence of evidence of findings being shared with practice staff and lessons learnt in some cases. However, overall patients concerns had been responded to in an appropriate manner. For example, we found, following one complaint, a change in the procedure and guidance to staff about giving patients information about treatments they may require. All staff had been spoken with and advised regarding the changes and the importance of explaining all aspects of care to patients. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and the practice had found no themes.

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 provide patients and their families with the best possible healthcare. This commitment was stated on the practice website. The practice had been in discussions with the NHS property service, CCG and neighbouring practice regarding the forecast growth in patient population. Plans were being considered regarding the best means to meet the forecast growth in patient numbers due to new housing developments within the area. The practice remained committed to delivering a friendly, caring, local accessible service to their patients.

We spoke with staff and they all knew and understood the vision and values including what their responsibilities were in relation to these. We looked at the minutes of the practice meetings and spoke with staff regarding their experience of the meetings. Whilst it was evident that all GPs were invited to contribute to discussion, staff told us they did not always felt listened to. They told us on occasions it was not evident how their contributions had informed the decision making process or conclusions reached. This may present a lost opportunity to maximise the skills and contributions of all members and grades of staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of policies and procedures and found that these were relevant to the needs of the practice. All policies and procedures were subject to an annual review or as appropriate in line with new guidance and legislation.

Staff were required as part of their induction to read relevant policies identified to them. Staff were invited to sign the information governance and confidentiality policy staff to show they had read and understood the content.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GPs led on specialist areas of care. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice 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. We saw that QOF data was regularly discussed at monthly action plan meetings to maintain or improve outcomes. The practice held monthly governance meetings. We looked at minutes from the last three meetings, March 2015, February 2015 and December 2014 and found that performance, quality and risks had been discussed.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk logs completed for each room which addressed a wide range of potential issues such as fire hazards. We saw that these were regularly revised and brought to the attention of staff.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that these addressed team performance and changes in practice. However, we found there was an absence of detail within them relating to discussions, actions allocated and evidence that these had been reviewed and progressed.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had distributed 250 surveys and had received 200 responses. The patients were generally happy with the availability and timing of appointments and thought clinical and administrative staff were good or excellent. Patients had reported difficulty getting through to a practice receptionist and the practice had responded by

Are services well-led?

Good

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

recruiting an additional member of reception staff to answer calls during periods of high demand. They also committed to evaluating the effectiveness of the position, and potentially increasing resources should the member of staff be insufficient to meet patient demand. The results and actions agreed from these surveys were available on the practice website.

The practice had an active Patient Participation Group (PPG). The PPG included representatives from various population groups; patients with long term conditions and carers. The PPG meet regularly and were actively involved with the development of services and facilities for patients such as; the newsletter, building an extension to the premises to increase the number of consultation rooms and providing the practice with a conference room facility.

The practice had gathered feedback from staff through daily informal discussions, appraisals and meetings such as the reception team meetings, staff meetings and monthly governance meetings. We reviewed the minutes of these meetings. The nursing team told us they found their meeting a helpful and supportive forum to discuss and raise concerns. They including issues relating to appointment timings, and staffing but would also address clinical matters where appropriate. Whilst all staff told us they felt happy and supported to give feedback during their appraisals, they also reported that they did not always feel fully engaged in decision making in formal meetings and felt their collective voice was not always listened to and responded to.

The practice had a whistleblowing policy which was available to all staff in the staff handbook, accessible in a manual folder and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice had recently supported a member of their nursing team to become a Queens Nurse. This is awarded to nurses who have committed to high standards of practice and patient centred care and required patients and the clinical team to provide feedback on their experiences of the staff member. Both the staff member and practice were extremely proud of the achievement.

We looked at seven staff files and saw that regular appraisals took place which included a personal development plan. However, we found that the practice manager had not received an appraisal and had conducted the nursing team's appraisals, independently of any clinical input.

The practice was a GP training practice aligned to the East of England Deanery. Staff we spoke to valued the opportunity to be a training practice as it assisted in maintaining their skills and knowledge. We spoke to one registrar who told us they felt valued, appreciated and supported by both the clinical and administrative team. However, we found an absence of joint clinical discussions held with the nursing and GP's.

The practice had completed reviews of significant events and other incidents and shared with staff informally and during formal significant incident management meetings.