Pelham Medical Group

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

We carried out an announced comprehensive inspection at Pelham Medical Group on 13 January 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 that meet the needs of the population it served.

We found the practice to be outstanding for the care of the population group older people.

Our key findings were as follows:

- Patients who use the service were kept safe and protected from avoidable harm. The building was well maintained and clean.
- All the patients we spoke with were positive about the care and treatment they received. The CQC comment cards and results of patient surveys showed that patients were consistently pleased with the service they received.
- There was good collaborative working between the practice and other health and social care agencies that ensured patients received the best outcomes. Clinical decisions followed best practice guidelines.
- The practice met with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.
- There were good governance and risk management measures in place. The leadership team were visible and staff we spoke with said they found them very approachable.

We saw several areas of outstanding practice:

- The practice employed a community care co-ordinator whose role was to visit older housebound patients who had complex needs in their own homes. This was to ensure they had a care plan in place and were receiving care and treatment which would reduce the risk of unplanned admissions to hospital. Data showed that there had been a 32% reduction in unplanned admissions to hospital between October to December 2014 compared with October to December 2013.

Summary of findings

- The practice provided a substance misuse service to vulnerable patients. The service was GP led and had the support of a drugs worker and family liaison worker. This enabled the service to support the families and children of patients who were substance misusers.
- The practice monitored all GP consultations to ensure all referrals to hospitals and other services had been completed.
- The practice had developed an innovative system to manage their asset register using an 'App' on an i pad. This enable staff to keep track of equipment and medicines ordered and when any maintenance was due or when medicines would expire.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above the local CCG average for all but one of the clinical indicators. Care and treatment was being considered in line with current guidelines and legislation. This included assessing capacity and promoting good health. Patient's needs were consistently met and referrals to other services were made in a timely manner. Staff worked with multidisciplinary teams. The practice undertook clinical audit and monitored the performance of staff. Staff had received training appropriate to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Feedback from patients about their care and treatment was positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able 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. Information about how to complain was available and the practice responded to complaints and comments appropriately.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The leadership team was visible and it had a clear vision and purpose which included; all decisions in respect of patient management and provision of services would be based upon clinical need and to be leaders not followers in addressing the health inequalities of their local community. 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.

Governance arrangements were in place and there were systems for identifying and managing risks. Staff were committed to maintaining and improving standards of care. Key staff were identified as leads for different areas in the practice and they encouraged good working relationships amongst the practice staff. Staff were well supported by the GPs and practice manager.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice employed a community care co-ordinator whose role was to visit older housebound patients who had complex needs in their own homes. This was to ensure they had a care plan in place and were receiving care and treatment which would reduce the risk of unplanned admissions to hospital. Data showed that there had been a 32% reduction in unplanned admissions to hospital between October to December 2014 compared with October to December 2013.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients. Nursing staff had lead roles in chronic disease management. The practice closely monitored the needs of this patient group. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. We heard from patients that staff invited them for routine checks and reviews. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the 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. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates

were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse.

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 this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided a range of options for patients to consult with the GP and nurse. Late night clinics were available four evenings a week. The practice was proactive in offering online services. Useful information was available in the practice and on the website as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability, 22 out of 42 patients on the practice register had received an annual health check in 2014. There was an action plan in place to improve the uptake of annual health checks in 2015. The practice offered these patients longer appointments. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and families with carer responsibilities.

The practice provided a substance misuse service to vulnerable patients. The service was GP led and had the support of a drugs worker and family liaison worker. This enabled the service to support the families and children of patients who were substance misusers.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. They had access to the practices' policy and procedures and discussed vulnerable patients at the clinical meetings.

Summary of findings

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 who experienced mental health problems including dementia. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review. Data for 2013/2014 showed 89.4% of patients diagnosed with dementia had received a face to face review in the previous 12 months. Documented care plans had also been completed for 89.4% of patients with other mental health problems such as schizophrenia, bipolar affective disorder and other psychoses.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice employed a motivational therapies counsellor to support this population group. Information was available for patients on counselling services and support groups.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from six patients all of which were positive about the care and treatment they received from the practice. Patients said staff were polite and helpful and always treated them with dignity and respect. Patients described the service as very good and said the nurses and GPs were always professional.

We spoke with ten patients during the inspection and they also confirmed that they had received very good care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of the national GP survey for 2014 where 116 patients had responded. Results showed that patients were generally positive about the service they received and the practice performed at or above the weighted CCG (regional) average in a number of areas. For example:

- 81% of respondents would recommend this surgery to someone new to the area - CCG local average: 79%
- 91% of patients said it was easy to get through to the practice on the phone - CCG local average: 75%
- 85% of respondents describe their overall experience of this surgery as good – CCG local average: 86%
- 87% of respondents describe their experience of making an appointment as good – CCG local average: 76%
- 91% of respondents find receptionists at this surgery helpful – CCG average: 88%

We looked at the results of the Practice's survey for 2014 which 123 patients had completed and saw they were also very positive about the services delivered.

These results were consistent with our findings on the day of the inspection.

We found that the practice valued the views of patients and saw that following feedback from surveys and from patients attending the practice; changes were made to improve the service.

Outstanding practice

- The practice employed a community care co-ordinator whose role was to visit older housebound patients who had complex needs in their own homes. This was to ensure they had a care plan in place and were receiving care and treatment which would reduce the risk of unplanned admissions to hospital. Data showed that there had been a 32% reduction in unplanned admissions to hospital between October to December 2014 compared with October to December 2013.
- The practice provided a substance misuse service to vulnerable patients. The service was GP led and had the support of a drugs worker and family liaison worker. This enabled the service to support the families and children of patients who were substance misusers.
- The practice monitored all GP consultations to ensure all referrals to hospitals and other services had been completed.
- The practice had developed an innovative system to manage their asset register using an 'App' on an i pad. This enable staff to keep track of equipment and medicines ordered and when any maintenance was due or when medicines would expire.

Pelham Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector and included a GP Specialist Advisor and a Practice Manager Specialist Advisor.

Background to Pelham Medical Group

Pelham Medical Group is situated in Grimsby and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Grimsby area. The practice provides services to 9425 patients of all ages. There is a significantly higher percentage of the practice population in the 65 years and over age group than the CCG and England average and there is a slightly higher percentage in the under 18 age group than the CCG and England average. The overall practice deprivation score is higher than the England average, the practice is 32.9 and the England average is 23.6.

The practice has four GP partners and two salaried GPs, four male and one female. There is one nurse practitioner, two practice nurses, two health care assistants (HCA) and a Community HCA/Care Co-ordinator. There is one business manager and one assistant practice manager. The practice has a team of secretarial, reception, administrative and support staff.

The practice provided services to their patients through a Primary Medical Services contract.

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed Core Care Links provides OOHs services for patients. Information for patients requiring urgent medical attention out of hours is available in the waiting area, in the practice information leaflets and on the practice website.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out an announced inspection 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
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 13 January 2015.

During our visit we spoke with a range of staff including two GPs, the senior nurse/nurse practitioner, the health care assistant, a receptionist and three administrators. We also spoke with the practice manager, assistant practice manager and the palliative care nurse who was visiting the practice. We spoke with four patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed six CQC comment cards where patients were able to share 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. For example an incident had been reported where a scanned letter had been entered into the wrong patient record.

We reviewed incident reports and minutes of meetings where incidents that had occurred over the past two years were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice had a summary of the different types of incidents that had occurred during the year so were able to identify trends and determine if their actions to prevent a recurrence were working.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. The practice discussed incidents at the weekly clinical meetings and the whole practice meetings which occurred every six to eight weeks. A dedicated meeting would be held if a significant event occurred. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of actions taken following incidents. For example the practice had changed their procedure when scanning letters into patient's records. Staff now had to check the patients NHS number and date of birth as well as their name to reduce the risk information being scanned into the wrong patient record.

National patient safety alerts were disseminated by e mail to practice staff who then took any action required. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us that where necessary, alerts were discussed at staff meetings to ensure all staff were aware of any action that needed to be considered.

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 staff had received relevant role specific training on safeguarding. 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 and document safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role. Staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The GP explained how they worked with the Health Visiting and Social Services teams when they had safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or patients with dementia. If a patient was subject to a child protection plan this was highlighted on their record.

GPs were appropriately using the required codes on the electronic records system to ensure risks to children and young people who were on looked after or child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and explained how they would liaise with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments

frequently. These were brought to the GPs attention, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, however information telling patients that they could ask for a chaperone was not visible in the waiting room or 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). Nursing staff, including health care assistants, acted as chaperones and understood their responsibilities, including where to stand to be able to observe the examination. All staff who chaperoned had Disclosure and Barring Service (DBS) checks completed and had received chaperone training.

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 procedure for ensuring that refrigerated medicines were kept at the required temperatures and the action to take in the event of a potential failure.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that the nurse had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, for example Warfarin. This included regular monitoring of patients in line with national guidance and appropriate action being taken based on the results of blood tests to ensure patients received the correct dose of medication.

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 secure at all times.

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 we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. External advice and support was available for practice staff and the IPC lead attended the local IPC link nurse meetings. All staff received induction training about infection control specific to their role and received annual updates. Staff we spoke with described the action they had taken when a patient had attended the practice recently and there was a risk they had been exposed to the Ebola virus.

The practice monitored the standards of cleaning in the practice regularly so any areas for improvement could be identified and actioned. We saw evidence that audits had been carried out in the last two years and that any improvements identified for action were completed.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. Staff were able to describe how they would use these to comply with the practice's infection control procedures. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. We saw that hand wash, disposable towels and hand gel dispensers were readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff confirmed they had completed training in infection prevention and control. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Good

Are services safe?

Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

The practice had systems for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice had developed an innovative system to manage their asset register using an 'App' on an i pad. This enable staff to keep track of equipment and medicines ordered and when any maintenance was due or when medicines would expire. They told us that all medical equipment was tested and maintained regularly and we saw records that confirmed this. For example weighing scales and blood pressure machines had all been checked within the last 12 months. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get an appointment to see a GP or nurse when they needed to.

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.

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 regular checks of the building and the environment. The practice had a governance policy which identified who the health and safety lead was and how health and safety would be managed and risks controlled. Health and safety information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. 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). Emergency medicines were available; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency equipment was working and that emergency medicines were within their expiry date and suitable for use. Records confirmed that equipment was checked regularly to ensure it was working and that medicines had not expired. All the medicines we checked were in date and fit for use.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. They all knew the location of the emergency airway equipment and medicines.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure,

Good

Are services safe?

adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received fire training and annual fire drills had been carried out.

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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We discussed with the practice manager, GP and nurses how NICE guidance was received into the practice. They told us that this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed. Implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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 the nurse that staff completed thorough assessments of patients' needs in line with national and local guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as substance misuse, mental health, sexual health and chronic disease management. 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. The nurses told us they continually reviewed and discussed new best practice guidelines, for example for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw that after these patients were discharged from hospital the community care co-ordinator followed them up to ensure that all their needs were continuing to be met.

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, for example for patients with suspected cancers who were referred and seen within two weeks. The practice had a system where each day all GP consultations were reviewed to confirm that all referrals required had been actioned. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audits. The practice showed us five clinical audits that had been completed. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example the practice had carried out an insulin initiation audit in 2014 to determine if patients who were started on insulin medication had effective control of their

Good

Are services effective?

(for example, treatment is effective)

blood sugar levels. The audit demonstrated that some patients did have better control but the practice identified that the original criteria needed to be reviewed and there was a plan to repeat it again.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). QOF data for 2013/2014 showed the practice was performing above the CCG and England average for all but one of the clinical indicators including asthma and chronic obstructive pulmonary disease (lung disease). The practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, peer supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should be involved in the audit process.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly 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 that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local and national benchmarking. This is a process of evaluating performance data from the practice and comparing it to other surgeries. This benchmarking data showed the practice had outcomes that were comparable to or better than other services. For example, data from November 2014 showed the practice value for emergency admissions to hospital the was 76.64 and the national value was 91.37.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training matrix and saw staff were up to date with attending mandatory courses such as basic life support, fire safety and safeguarding children and adults. The training matrix outlined what training each member of staff had attended if any refresher training was required and at what intervals this should occur.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by 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. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice had recently employed a nurse practitioner and practice nurse and had engaged an external training company to support their training and development. The nurses had completed training in areas specific to their role, for example asthma, diabetes, cervical smears and immunisations. The staff we spoke with confirmed they had access to a range of training that would help them function in their role.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff described how they had shadowed other staff in the practice during their induction period so they became familiar with how the practice worked. Staff told us that role specific induction, for example immunisation training for nurses was available for new staff.

There was a process in place to manage poor performance of staff members.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to the 'duty doctor' for that day. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The practice held multidisciplinary team (MDT) meetings every week to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in the patients' care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We spoke with the palliative care nurse who told us that the practice staff worked well with other MDT members and communication and collaborative working was very good.

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 through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use. The

For emergency patients, there was a policy of providing 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 and planned to have this fully operational by March 2015. (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.

Patients could also register for access to an electronic system which gave them a summary of their past consultations and access to test results and letters.

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 to 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). 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical

Good

Are services effective?

(for example, treatment is effective)

procedures a patient's written consent was obtained and then documented in the electronic patient record. The consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

It was practice policy for all new patients registering with the practice to complete a health questionnaire to assess their past medical and social histories, care needs and assessment of risk. Patients were then offered a new patient medical with the practice nurse. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were followed up if they had risk factors for disease identified at the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. We saw that 22 out of 42 patients on the register had received an annual health check in 2014. There was an action plan in place to improve the uptake of annual health checks in 2015 and to date eleven patients had been invited for health checks and eight had attended. The number of patients with mental health problems who had a comprehensive care plan documented in their record which had been agreed between individuals, their family and/or carers as appropriate was 89.4%. This was 3.1% above the local CCG average and 14.9% above the national average.

QOF data for 2013/2014 showed the practice had identified the smoking status of 92.1% of patients over the age of 15 and 90.3% of these patients had been offered support and treatment within the preceding 12 twelve months. Also the practice had recorded the smoking status of 97.8% of patients with conditions such as heart disease, stroke**,** hypertension, diabetes, respiratory problems, asthma and mental health conditions and 95.9% had a record of an offer of support and treatment recorded in their records within the preceding 12 months. Performance for smoking cessation support for these patients was similar to or above average for the local CCG area. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake in 2013/2014 was 78.8%, which was in line with others in the CCG area. The practice provided us with data up to January 2015 which showed performance had improved to 83%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The nurses were responsible for following up patients who did not attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for immunisations was above the CCG average for children aged 12 months and 5 years, the practice scored above 90% in all the immunisations. They were slightly below the CCG average for two of the three immunisations for children aged 24 months, however still scored above 95% for both. Again there was a clear policy for following up non-attenders by the practice.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2014 which had 116 respondents and a survey undertaken by the practice's patient participation group (PPG) which had 123 responses. The evidence from these sources showed patients were satisfied with how they were treated. This was with compassion, dignity and respect. For example, data from the national patient survey showed 82% of respondents stated the last GP they saw or spoke to was good at treating them with care and concern and 82% said the GP was good at listening to them. The satisfaction rates for the nurses for these two areas were 92% and 93% respectively.

Patients were also positive about their overall experience of the practice with 85% saying their overall experience of the surgery was good and 81% saying they would recommend the surgery to someone new to the area.

We received six completed CQC comment cards and spoke with four patients during the inspection. All of the feedback was positive about the service experienced. Patients said staff were polite and helpful and always treated them with compassion, dignity and respect.

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy 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 area was open but we observed no confidential information being discussed from the waiting area. There was a room available if patients wished to discuss a matter with the reception staff in private, and there was a notice informing patients that this was available. A self-check in screen was available for patients to use if they did not want to go to the reception desk.

We observed reception staff treating patients with respect and being extremely tactful when dealing with requests. Data from the national patient survey 2014 showed 91% of respondents found the reception staff helpful.

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.

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 national patient survey showed 75% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. The satisfaction rates for the nurses for these two areas were 91% and 96% respectively. As a result of feedback from the surveys the practice undertook professional external training on 'Patient Care' to improve their consultation skills.

Feedback from patients also indicated that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. We saw evidence that care plans were discussed with patients.

Staff told us that translation services were available for patients who did not have English as a first language. There were no notices in the reception area informing patients about the translation service but it was available on the electronic display board in the waiting area.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

Notices and leaflets in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. This included MIND for help with mental health issues and services for support following bereavement. The practice's computer system alerted GPs and nurses if a patient was a carer. The nurses told us that they would signpost patients who were carers to support groups and services that could help them.

Patients receiving end of life and palliative care were well supported by the GPs and nurses in the practice. We spoke with the palliative care nurse who told us that there was good collaborative working between the practice staff, palliative care team and district nurses and patients received good care. Information on support services was available for patients and carers.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had introduced the nurse practitioner 'Rapid Access Clinic' to enable patients with more minor illnesses to have quick and accessible access to appointments. Feedback from patients confirmed they could be seen quickly when required. The practice also provided family planning 'drop in' clinics.

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. The practice identified a need for their older housebound population to receive equity of care and for primary care services to be taken out into the community. Each older person had a care plan developed and agreed with the GP. The senior Health Care Assistant (HCA) co-ordinated a recall system so all patients were seen regularly in their own home. The senior HCA was also supported by a newly appointed unplanned admissions care co-ordinator. This role was to enhance the work required for the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme" which the practice was participating in.

This was a strategy introduced in 2014 where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. All patients who had had an unplanned hospital admission were now contacted by the care co-ordinator after discharge to provide support and arrange any services or help that the patient required. Data showed that there had been a 32% reduction in unplanned admissions to hospital between October to December 2014 compared with October to December 2013.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example the practice had introduced the minor illness clinic each morning which was led by the specialist nurses. Less serious conditions were now dealt with promptly by the nurses and, consequently, the GPs had more routine appointment time available.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The majority of the practice population were English speaking but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care.

The premises and services had been designed to meet the needs of people with disabilities. The building was a purpose built health centre with all the clinical services delivered on the ground floor which were accessible for all patients. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. A hearing loop was installed to assist patients who had hearing difficulties.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice provided an assessment and treatment service for patients who were substance misusers. The service was GP led and had the support of a drugs worker and family liaison worker. This enabled the service to support the families and children of patients who were substance misusers.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

Patients could make appointments in different ways, either by telephone, face to face or online, via the practice website. The surgery was open from 8.00am to 6.00pm Monday to Friday and offered late night appointments until

Good

Are services responsive to people's needs?

(for example, to feedback?)

7.30pm four evenings a week. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. The GPs, nurses and receptionists all told us that if patients needed to be seen urgently they were given an appointment the same day. Patients could register to receive text reminders for their appointments.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor or nurse on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Data from the national patient survey showed 87% of patients described their experience of making an appointment as good. Reception staff told us they felt the system worked well and they felt they could always offer patients an appointment.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This was publicised on the electronic noticeboard in the waiting room, on the website and in information leaflets. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people.

The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse.

Patients could order repeat prescriptions by post, in person or on line. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to make a complaint was on the practice website, in the complaints information leaflet and displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by.

We saw that information was available to help patients understand the complaints system. There was a complaints leaflet available, a summary in the patient information leaflet and details on the practice website. Patients we spoke with told us they would speak with a member of staff if they were not happy with the service. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff were aware of how to deal with concerns raised by patients and described how they would support someone who was not happy with the service.

The practice had received 17 complaints between April 2013 and April 2014. We saw that these were dealt with in a timely way and had been investigated and satisfactorily handled. We saw that where relevant GPs, nurses and the practice manager had met with the complainant to discuss the issues raised and where possible the complaint had been resolved. The practice had a summary of the different types of complaints that had occurred during the year so were able to identify trends and determine if their actions to prevent a recurrence were working. They had also provided training for all staff as a result of identifying areas for improvement following complaints, for example record keeping and patient care.

We saw that the practice had received a number of cards and letters thanking staff for their kindness, support and care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality healthcare and promote good outcomes for patients. We found details of their mission statement, vision and practice values were part of the practice's strategy. These values were clearly displayed in the practice and on the website. The practice vision and values included putting their patients at the heart of all practice developments and services; consulting their patients on the needs and demands of the practice and inviting patient discussion and feedback; all decisions in respect of patient management and provision of services would be based upon clinical need and to be leaders not followers in addressing the health inequalities of their local community. The doctors, nurses and all other staff were dedicated to offering a professional service and helping to keep patients up to date with news and information about the practice.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice had a Customer Care and Quality Standards leaflet which outlined how the practice would provide a good service for their patients. This included the standards patients could expect from staff and the practice, how the practice would monitor if it was meeting those standards and how it would address any issues identified.

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 nine of these policies and procedures and saw they had been reviewed annually and were up to date.

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 one of the GP partners was the lead for safeguarding and governance. The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice if they had any concerns.

The practice used the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance. The QOF data for this practice showed it was performing above the local CCG and national average in all but one of the indicators. We saw that QOF and CCG data was regularly discussed at the team meetings and action agreed where necessary to maintain or improve outcomes.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire safety. The practice monitored risks on a regular basis to identify any areas that needed addressing documented the findings.

The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice was undertaking audits for the prescribing of anticoagulants (medicines that thin the blood). This ensured they were using these medicines in line with clinical guidelines and were using the most cost effective treatment available.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that practice meetings for all staff were regularly, at least monthly and these were used for staff to raise concerns, to share information and to discuss lessons learned from incidents. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place and there were policies or procedures for

Are services well-led?

Good

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

disciplinary issues and bullying and harassment. We saw that mechanisms were in place to support staff and promote their positive wellbeing. The staff we spoke with told us they were well supported and the staff worked well as a team.

The practice had gone through a challenging period of time in 2014 with the loss of four members of staff from the clinical team over a short period of time. However the leadership team had continued to support staff so the practice could continue to provide a high quality service to its' patients.

Seeking and acting on feedback from patients, the public and staff

The practice had gathered feedback from patients through the Patient Participation Group (PPG), surveys and complaints received.

The practice had an established PPG (called the 'Patients Helping Patients' group) which met quarterly. There was also a virtual group for patients that couldn't attend meetings. There was information on the practice website and in the waiting room encouraging patients to become involved in the PPG and the virtual group. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. We saw changes had been made following feedback from the PPG, for example the group had suggested using the TV screen in the waiting room to make patients aware they could book longer appointments if they had complex health problems or wanted to discuss multiple issues. This was to assist in reducing clinic sessions running late and the practice was going to monitor this in January 2015 to see if improvements had occurred.

We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box on the reception desk in the surgery and patients could also provide feedback through the practice website. We found that the practice was very open to feedback from patients. The practice had also commenced the Friends and Family feedback project.

The practice had undertaken a staff survey in 2014 and also gathered feedback through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at appraisal records and saw they included a personal development plan. Staff told us that the practice was very supportive of training, for example one nurse told us they had done the insulin initiation course.

The practice was a GP training practice for medical students. However due to the challenges the practice had faced during 2014 with GPs leaving, at the time of the inspection placements for the students had been suspended. This decision had been made to enable the practice to continue to deliver high quality healthcare and promote good outcomes for their patients.

The practice had completed reviews of significant events and other incidents and shared the learning with staff at meetings to ensure the practice improved outcomes for patients. For example, following an error when a blood test had been booked better guidance was required for reception staff and a new flowchart was developed.