Belvidere Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
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 Belvidere Medical Practice on 2 June 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding in providing caring and responsive services. We found it good for providing safe, effective and well led services. It was also outstanding for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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, empathy, 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 and that there was continuity of care, with urgent appointments available the same day. The practice provided extended hours appointments with their GPs, respiratory nurse and counselling service. The practice had also increased the flexibility and length of time of their GP appointments to 12 minutes instead of 10 to ensure patients' needs were met.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from patients, which it acted on.

We saw the following areas of outstanding practice:

- The practice employed a care co-ordinator to support and facilitate care for vulnerable patients. For example, the practice had identified 110 frail and vulnerable patients registered with their practice and 96 of these patients had an agreed care plan in place. The care co-ordinator also co-ordinated three monthly health reviews by a GP and telephoned patients following any hospital admissions to check on their health and wellbeing. In addition, they proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group.
- Extended hours appointments were available with the GPs, respiratory nurse and the practice's counselling service.
- The practice employed a counsellor for patients experiencing mental health difficulties such as low mood, depression and anxiety. For 2014-2015 the practice had made 57 referrals to this service and 317 counselling sessions had been provided for these patients. Fifty-two out of 62 patients with a diagnosis of dementia had received an annual health review in the last 12 months.

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

Importantly the provider should:

- Introduce a system to review significant events over time to identify any trends in the type of incidents that may have occurred at the practice.
- Introduce a risk log to ensure that identified risks are monitored and rated and mitigating actions recorded to reduce and manage the risk.
- Ensure that all the staff receive regular appraisals.

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 to support improvement however there was no system in place to monitor and review trends in significant events. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence 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 some staff. The practice manager and practice nurses had not received a recent appraisal.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data from the national patient survey showed that patients rated the practice higher than others in nearly all aspects of care. For example, 92% of practice respondents said the GP was good at involving them in decisions about their care. This was above the regional Clinical Commissioning Group (CCG) average of 87% and the national average of 82%. Ninety-four per cent of respondents said the last GP they saw or spoke to was good at treating them with care and concern and 99% had confidence and trust in the last nurse they saw or spoke to. These were above the CCG and national averages.

Patients said they were treated with empathy, kindness, dignity and respect and they were involved in decisions about their care and treatment. The GPs told us, and we saw, that they personally fetched patients from the waiting room rather than use an electronic calling system. They told us they did this to ensure a personalised and welcoming service for all of their patients. Artwork had been

Summary of findings

displayed on the walls in the practice and a bird table had been put outside one of the windows to provide a more welcoming and relaxed environment. Information to help patients understand the services available was easy to understand.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding 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.

The practice employed a care co-ordinator to support and facilitate care for vulnerable patients. The care co-ordinator facilitated health reviews for frail older people and telephoned patients following any hospital admissions to check on their health and wellbeing. They proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group. Patients with a learning disability were offered an annual health check. Twenty-six out of 36 patients with a learning disability had received an annual health check in the last 12 months to ensure their needs were met. Easy read leaflets were provided to these patients to help them to understand the care and treatment they were offered.

The practice employed a counsellor for patients experiencing mental health difficulties such as low mood, depression and anxiety. They also referred patients who were experiencing interpersonal distress such as relationship problems, domestic abuse and social problems. In 2014-2015 the practice had made 57 referrals to this service and 317 counselling sessions had been provided for these patients.

Patients said they found it easy to make an appointment and told us that there was continuity of care, with urgent appointments available the same day. The practice had increased the flexibility and length of time of their GP appointments to 12 minutes instead of 10 to ensure patients' needs were met. Data from the national patient survey showed that 92% of respondents said they were satisfied with the appointment system. This was significantly higher than the regional average of 81% and the national average of 75%. The practice provided extended hours appointments with their GPs, respiratory nurse and counselling service to meet the needs of working age people and school children.

Summary of findings

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

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 the management. The practice had a number of policies and procedures to govern activity. There were some systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients, which it acted on. The patient participation group (PPG) was active. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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. 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. It had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had identified 110 frail and vulnerable patients registered with their practice. Ninety-six of these patients had an agreed care plan in place. The practice care co-ordinator facilitated additional support for these patients. For example, a three monthly health review by a GP and a telephone call to check on their health and wellbeing following any hospital admissions.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients were offered a structured annual review to check that their health and medication needs were met. For example, 311 out of 311 of patients with asthma and 241 out 260 patients with diabetes had received a medication review in the previous 12 months. 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

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. For example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives.

The care co-ordinator proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group.

Summary of findings

The practice had completed an audit for pregnant women to monitor if they had received the influenza immunisation during pregnancy. Following the audit and changes made to the service provided, we saw that the number of pregnant women who had received the influenza immunisation had increased by 10%.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended opening hours were available to support working age people to access GP, nursing and counselling services. The practice was proactive in offering online services 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

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of vulnerable patients such as those with a learning disability, children with a child protection plan in place and patients who had carers. It had carried out annual health checks for 75% of people with a learning disability in the previous 12 months and had systems in place to follow up the outstanding checks. 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.

There was a robust system in place for monitoring children and vulnerable adults who frequently attended the accident and emergency A&E department. The staff member who monitored the A&E attendances brought any concerns to the attention of the GPs. The GP safeguarding lead told us they reviewed these attendances and if a concern was highlighted, patients were provided with an appointment to discuss any health concerns.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Fifty-two out of 62 patients with a diagnosis of dementia had received an annual health review in the last 12 months. 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 counsellor for patients experiencing mental health difficulties such as low mood, depression and anxiety. They also referred patients who were experiencing interpersonal distress such as relationship problems, domestic abuse and social problems. We saw that for 2014-2015 the practice had made 57 referrals to this service and that 317 counselling sessions had been provided for these patients.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

All of the seven patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 41 patient comment cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were mainly positive. Patients told us the staff were helpful, caring, supportive and friendly and that they were treated them with kindness, dignity and respect. Most said that the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Three of the comments were less positive about the attitude of one member of staff. Patients told us that the practice was always visibly clean and tidy and that the appointment system was easy to use and met their needs.

The results from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 96% of respondents said that their overall experience of the practice was good or very good and that 91% of respondents would recommend the practice to someone new to the area. This was above the Clinical Commissioning Group (CCG) regional average of 90% and 83% respectively.

Areas for improvement

Action the service SHOULD take to improve

The provider should introduce a system to review significant events over time to identify any trends in the type of incidents that may have occurred at the practice.

The provider should introduce a risk log to ensure that identified risks are monitored and rated and mitigating actions recorded to reduce and manage the risk.

The provider should ensure that all the staff receive regular appraisals.

Outstanding practice

The practice employed a care co-ordinator to support and facilitate care for vulnerable patients. For example, the practice had identified 110 frail and vulnerable patients registered with their practice and 96 of these patients had an agreed care plan in place. The care co-ordinator also co-ordinated three monthly health reviews by a GP and telephoned patients following any hospital admissions to check on their health and wellbeing. In addition, they proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group.

Extended hours appointments were available with the GPs, respiratory nurse and the practice's counselling service.

The practice employed a counsellor for patients experiencing mental health difficulties such as low mood, depression and anxiety. For 2014-2015 the practice had made 57 referrals to this service and 317 counselling sessions had been provided for these patients. Fifty-two out of 62 patients with a diagnosis of dementia had received an annual health review in the last 12 months.

Belvidere Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Belvidere Medical Practice

Belvidere Medical Practice moved to this location in 1991 and provides primary health care to patients living in Shrewsbury, Shropshire. The practice has a contract to provide General Medical Services for patients. This is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice provides a number of specialist clinics and services. For example, long term condition management including asthma, diabetes and high blood pressure. It also offers a phlebotomy service (the taking of blood from a vein for investigations), family planning, childhood and travel vaccinations and a counselling service.

A team of five GPs; four practice nurses; a counsellor; a practice manager and seven receptionists and administrative staff provide care and treatment for approximately 5200 patients. There are three female and two male GPs. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen at Shropdoc out of hours service when the practice is closed.

The practice is open between 8.30am until 1pm and 1.30pm until 6pm Monday to Friday. Appointments are from 8.30am to 10.54am every morning and 3pm to 17.48pm daily. Extended hours appointments are offered on Tuesdays, 6pm until 7.30pm.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a health visitor, a manager of a care home for older people and the chairperson of 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 did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 2 June 2015 at the practice. During our inspection we spoke with the two GP partners; a salaried GP; a practice nurse; two receptionists; a care co-ordinator; an administrator; the practice manager and seven patients. We observed how patients were cared for. We reviewed 41 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. For example, a practice nurse described to us the changes made following an incident where a patient received an incorrect immunisation.

We reviewed safety records, incident reports and significant events. We saw that all the significant events were recorded, investigated and action plans were put in place when changes needed to be made. However, there was no system in place to review significant events over time to identify any trends in the type of incidents that may have occurred at the practice.

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 four years and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff told us that learning from significant events was emailed to them with a read receipt to demonstrate that they had read and understood them. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, following a significant event involving a patient who had been over requesting a medicine used to control pain, changes to the way repeat prescriptions were provided had been made. These changes were communicated to all the staff by email.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, a practice nurse told us of an alert they had received regarding the recall of some syringes. They also told us alerts were discussed at regular clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records that showed most 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. They were aware of how to contact the relevant agencies in working hours and out of normal hours. Contact details were available in the safeguarding policies for staff to refer to.

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

There was a system in place 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. A register of vulnerable adults and children with a child protection plan in place was maintained and the GP safeguarding lead was aware of these patients. We saw minutes from meetings that had been held with other professionals such as a health visitor, the community psychiatric nurses and palliative care nurses to discuss the care of vulnerable adults and children. The register and records demonstrated good liaison with partner agencies.

There was a robust system in place for monitoring children and vulnerable adults who frequently attended the accident and emergency (A&E) department. The staff member who monitored the A&E attendances brought any

concerns to the attention of the GPs. The GP safeguarding lead told us they reviewed these attendances and if a concern was highlighted, patients were provided with an appointment to discuss any health concerns.

There was a chaperone policy for staff that chaperoned to refer to for guidance and notices were displayed in the waiting room and consulting rooms informing patients of their right to have a chaperone present during an intimate examination. 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. Reception staff told us they acted as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Following a risk assessment day facilitated by the Medical Protection Society it was decided that all reception and administrative staff required a DBS check to be completed and these had been applied for. The practice manager had made the GPs aware that there was only one administrative staff member who had a Disclosure and Barring Service (DBS) check in place that could chaperone. The practice manager told us that when the DBS checks had been received for the remaining staff, they would then be able to chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff described how they 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 practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training and updates to administer vaccines.

There was a system in place for the management of high risk medicines, which included audits and monitoring in line with national guidance. This work was supported by the pharmacist for the local clinical commissioning group (CCG). The pharmacist had carried out an expenditure and progress audit to look at 12 prescribing indicators to compare the prescribing habits of this practice with other practices in the CCG. We saw that the practice had achieved 11 of the 12 indicators and had achieved the best results within the CCG.

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.

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. 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 training to enable them to provide advice on the practice infection control policy. Most staff had received training about infection control specific to their role. Infection control had been identified in the practice's training matrix as essential training for all staff. We saw minutes from an infection control meeting which demonstrated that issues around infection prevention had been discussed. The practice had an annual rolling infection control audit programme in place. We saw that an infection control audit had been carried out in June 2014 and actions required identified. We saw that most of these actions had been carried out. For example, bins with pedals had been put in place at the practice and the infection control policy had been updated. However, it had been identified that the fabric covered seats in the practice needed to be replaced with wipeable seats but this had not been carried out. The practice manager told us they were aware of this and had plans to carry this out.

Good

Are services safe?

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.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that all staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that a legionella risk assessment had been completed in April 2015 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. 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.

Equipment

Staff we spoke with told us they had enough equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records that demonstrated all portable electrical equipment had been tested in January 2015 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in November 2014 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the DBS. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that annual and monthly checks of the building had been carried out. This included a fire risk assessment and weekly fire alarm testing; emergency lighting tests and an assessment of the internal and external maintenance requirements of the building. The practice also had a health and safety policy for staff to access on the practice's computer system. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

The practice had invited the Medical Protection Society (MPS) to carry out a patient safety survey to support the practice in the identification of risks to patients. The MPS is a protection organisation for medical, dental and healthcare professionals. The survey covered the key areas of appointments, patient confidentiality and prescribing. We saw that where risks were identified that action plans had been put in place to address these issues.

The practice had measures in place to identify and respond to risks. However, there was no overarching risk log to ensure that identified risks were monitored and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that most staff had received training in basic life support and that updates had been arranged. We saw that emergency equipment was available including access to oxygen, adult and paediatric airway management equipment and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular

Good

Are services safe?

fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly.

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 (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of IT, adverse weather, unplanned sickness and the loss of domestic services. We saw that the business continuity plan included important contact numbers for use in the event of the loss of one of these services.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised annual fire drills. We saw that there was an oxygen warning sign on the door of the room where the oxygen was stored. This is required to alert the fire service of the presence of oxygen if a fire were to occur at the practice.

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) through the practice computers and a mobile app on their mobile phones. The GPs told us they discussed NICE guidelines at their weekly GP meetings and implemented those that were applicable to the care and treatment they delivered. 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 when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The practice employed a specialist respiratory nurse who had received specialised training to support them in this role. 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.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. For example, the GPs we spoke with used national standards for the referral of patients with suspected cancers to be seen within two weeks. We saw that in the previous 12 months 197 patients with suspected cancers had been referred and 100% of these patients seen within two weeks.

Discrimination was avoided when making care and treatment decisions. 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 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, scheduling clinical reviews, monitoring accident and emergency attenders and medicines management.

The practice showed us five clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of pregnant women who had received the influenza immunisation during pregnancy had been carried out. Following the audit it was identified that 36% of these patients had not been given the immunisation. To improve the uptake of this immunisation rate an action plan was put in place for GPs to offer the influenza immunisation during the initial booking consultation. Following these changes, a follow up audit was carried out which demonstrated that this figure had been reduced to 26%. However, three of these patients had been offered the immunisation but had refused it. This demonstrated that outcomes in preventing influenza in pregnant women had been improved by 10%. Other examples included audits of patients with coeliac disease, prescribing trends and of medicines prescribed for patients.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients against national screening programmes. 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. For example, 92% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and heart disease. The 2013 -2014 QOF data for this practice showed it was performing lower than national standards for the percentage of patients with a diagnosed mental illness. Only 31.8% of these patients had an agreed care plan in place compared with the national average of 86%. We saw that the practice had taken action to address this and the most up to date data demonstrated this had been increased to 77%. We also saw that the practice had taken actions to increase the percentage of patients whose notes recorded a smoking status in the preceding 12 months. We saw that this had increased from 89% to 96% which was above the national average of 95%.

Good

Are services effective?

(for example, treatment is effective)

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 practice followed the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw minutes that confirmed this.

The practice also participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to or above other services in the area. For example, the CCG pharmacist had carried out a prescribing performance audit for expenditure and progress. This looked at 12 prescribing indicators to compare the prescribing habits of this practice with other practices in the CCG. We saw that the practice had achieved 11 of the 12 indicators and had achieved the best results within the CCG.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory training identified by the practice. For example, annual basic life support.

We saw there was a good skill mix among the GPs. Two GPs had additional diplomas in sexual and reproductive medicine, one GP had a diploma in children's health and four GPs had diplomas in obstetrics and gynaecology. The respiratory nurse had completed a degree level module in chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

All the GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. 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.

Some staff had undertaken annual appraisals that identified learning needs from which action plans were documented. However, we saw that the practice nurses and practice manager had not received a recent appraisal. For example, one practice nurse told us they had not received an appraisal in six years. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example one of the practice nurses was being supported to complete a diploma in asthma management. Practice meetings for the whole team were only held twice a year. Some staff we spoke with told us they would like more frequent staff meetings.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and cervical cancer screening.

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 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. There was a dedicated data management clerk who oversaw this. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well. We saw that the data management clerk had summarised every patient's record ensuring that the clinical staff had access to their past medical history. This helped to ensure safe and effective care was provided in a consistent way.

The practice was commissioned for the enhanced service for the care of patients with learning difficulties. This aims to encourage GPs to identify registered patients aged 14 and over who are known to the local authority because of

Good

Are services effective?

(for example, treatment is effective)

their learning disabilities. The practice worked with the community learning disability service to ensure those that patients who did not attend for their annual health review were brought to their attention.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district and palliative care nurses and decisions about care planning were documented in patients' records.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a safe fax system to share information with the local GP out-of-hours service, Shropdoc. This enabled patient information to be shared in a secure and timely manner. The practice used the referral assessment service to make referrals to other services. Multidisciplinary meetings were held with other professionals such as district and palliative care nurses to ensure appropriate information sharing took place to support patients.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 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. Staff had received recent training in the mental capacity act. We saw that there was a template in the care plans for patients with dementia. This provided support and guidance to GPs when making best interest decisions for patients who lacked the capacity to make decisions for themselves.

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 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. We saw that there was a form to obtain informed written consent for minor surgery which was scanned into patients' records.

Health promotion and prevention

The practice offered a health check with the practice nurse 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. Patients with a learning disability or were on long term medication received a new patient health check with a GP. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a diagnosis of dementia and 52 out of 62 had received an annual health check in the last 12 months. The practice had identified 732 patients over the age of 16 who smoked and 98% of these had received smoking cessation advice or been referred to 'Help To Quit'. Similar mechanisms of identifying 'at risk' groups were used for patients who were overweight and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 85% which was above the national target of 80%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice monitored these patients. We saw that the practice was proactive in promoting screening for cancers. For example, 82% of eligible patients had received breast screening and 52% of eligible patients had received screening for bowel cancer.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG.

Outstanding ☆

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 carried out during January-March 2014 and July-September 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 96% of respondents said that their overall experience was good or very good. These results were above the regional Clinical Commissioning Group (CCG) average of 90% and the national average of 85%. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example, 96% of respondents said the GP was good at listening to them. This was above the CCG regional average of 93% and the national average of 89%. The data also showed that 98% of respondents had confidence and trust in the last GP they saw or spoke with compared with the CCG average of 97% and the national average of 95%. Ninety-nine per cent of respondents said they had confidence and trust in the practice nurse. This was above the regional CCG average of 98% and the national average of 97%.

We looked at the results of the Family and Friends test for April 2015 which asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment. We saw that 90% of respondents said they would recommend this practice.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 41 completed cards and the majority were positive about the service experienced. Most patients said they felt the practice staff were helpful, caring, supportive and friendly. They said staff treated them with kindness, dignity and respect. Three comments were less positive about the attitude of one staff member. We also spoke with seven patients on the day of our inspection. All of these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The GPs told us, and we saw, that they personally fetched patients from the waiting room rather than use an electronic calling system. They told us they did this to ensure a personalised and welcoming service for all of their patients.

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 saw that consultation and treatment room doors were closed during consultations and conversations that took 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 waiting room and reception desk were separated by a glass wall. This prevented patients from overhearing potentially private conversations between patients and reception staff. If a patient wished to speak to a receptionist in private, receptionists told us they took patients to a private room. The national patient survey showed that 93% of respondents said they found the receptionists at the practice helpful. This was above the CCG average of 90% and national average of 87%.

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 they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area and on the practice's website stating their zero tolerance for abusive behaviour. This was helpful to receptionists in helping them to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey carried out during January-March 2014 and July-September 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the survey showed 92% of practice respondents said the GP was good

Are services caring?

at involving them in decisions about their care and 92% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG averages of 87% and 91% and the national averages of 82% and 86% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

With the support of the CCG, the practice had identified 110 frail and vulnerable patients registered with their practice. We saw that additional support was provided for these patients and that 96 of these patients had an agreed care plan in place. The practice employed a care co-ordinator to facilitate and co-ordinate this support. For example, we saw that frail older people received a three monthly health review by the GP. They also received a telephone call from the practice following any hospital admissions to check on their health and wellbeing.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 94% of respondents to the national patient survey carried out during January-March 2014 and July-September 2014 said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional average of 90% and the national average of 85%. 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.

Notices in the patient waiting room and on the practice's website informed patients how to access a number of support groups and organisations. The care co-ordinator and data clerk maintained a register of patients who were carers and the practice's computer system alerted GPs if a patient was also a carer. Patients known to be carers were provided with care plans and sign posted to support agencies such as Age UK. We saw that the care co-ordinator proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. We saw that practical advice about what to do in times of bereavement was available for patients on the practice's website. GPs also referred patients to their in house counsellor for adjustment to life events counselling such as bereavement, redundancy and partnership break-up.

Outstanding ☆

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 practice employed a counsellor for patients experiencing mental health difficulties such as low mood, depression and anxiety. They also referred patients who were experiencing interpersonal distress such as relationship problems, domestic abuse and social problems. We saw that for 2014-2015 the practice had made 57 referrals to this service and that 317 counselling sessions had been provided for these patients.

The practice also employed a care co-ordinator to support and facilitate care for vulnerable patients. The care co-ordinator facilitated health reviews for frail older people and telephoned patients following any hospital admissions to check on their health and wellbeing. In addition, they proactively supported young carers and liaised with voluntary organisations such as the British Red Cross young carers service to support this vulnerable group.

Patients with a learning disability were offered an annual health check. We saw that there were 36 patients on the practice's learning disability register. Twenty-seven of these patients had received an annual health check in the last 12 months to ensure their needs were met.

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. For example, we saw that at the suggestion of the PPG, artwork had been displayed on the walls in the practice and that a bird table had been put outside one of the windows. This provided a more welcoming and relaxed environment.

The GPs told us that they regularly engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. One of the GPs showed us benchmarking data which demonstrated how the practice compared with other practices within the CCG. For example, prescribing rates and the referral rates of patients to other services. We saw that the practice performed higher in these areas when compared with other practices in the CCG.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed the equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training had been completed by each member of staff.

The practice recognised the needs of different groups in the planning of its services. Services for patients were provided on the ground floor of the practice. 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. Facilities for patients with mobility difficulties included disabled parking spaces; step free access to the front door of the practice; electronically operated doors; a wheelchair; disabled toilets and a hearing loop for patients with a hearing impairment. Information about the practice was available in large print for patients with a visual impairment and in an easy read format for patients with a learning disability.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care. We saw that there was a poster displayed in the waiting area informing patients of this.

The practice provided care and support to several older patients and patients living in care homes who could not leave their homes. Patients over 75 years of age had a named GP to ensure continuity of care. We spoke with the manager of one of the care homes who told us the practice always responded to their concerns about patients on the day they were contacted. Patients with learning disabilities were provided with annual health reviews at the practice and provided with double appointments to ensure their needs were met.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

There were no homeless patients registered with the practice but the practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of culture, religion or sexual preference.

Access to the service

The practice opened between 8.30am until 1pm and 1.30pm until 6pm Monday to Friday. Appointments were from 8.30am to 10.54am every morning and 3pm to 17.48pm daily. GP extended hours appointments were offered on Tuesdays, 6pm until 7.30pm. The practice also provided extended hours access to their respiratory nurse and counselling service to meet the needs of working age people and school children. Pre-bookable appointments were available up to six weeks in advance. The practice had increased the flexibility and length of time of their appointments to 12 minutes instead of 10 to ensure patients' needs were met.

Comprehensive information was available to patients about appointments on the practice website and displayed at the practice. This included how to arrange urgent appointments and home visits and how to book appointments through the practice's 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 Shropdoc was provided to patients on the practice's website.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 92% of respondents said they were satisfied with the appointment system. This was significantly higher than the CCG regional average of 81% and the national average of 74%. Ninety-one per cent of respondents said they found it easy to get through to the practice on the phone. This was above the CCG regional average of 84% and the national average of 74%. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

Patients were informed how to complain on the practice's website and the complaints policy was also displayed in the practice. A leaflet developed by the Royal College of General Practitioners was available on the practice's website. This informed patients how to complain to other authorities such as the Care Quality Commission, NHS England and the health Ombudsman. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at four complaints received in the last 12 months and found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw that learning from them was shared electronically with staff so they were able to learn from them. We looked at their annual complaints review report for the previous 12 months and saw that there were no trends in the complaints received.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included, to provide high quality general medical services to patients by putting patients at the centre of everything they do. To provide these services in a safe, professional and comfortable environment through updating of clinical skills and training specific to their individual needs.

We spoke with eight members of staff and they all knew and clearly understood the vision and values and what their responsibilities were in relation to these. On the day of our inspection, we were provided with statements from staff outlining their roles and responsibilities. The statements also included their personal aims for the practice which echoed the vision of the practice as a whole.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's computer system. We looked at 10 of these policies and procedures and saw that they had all been reviewed within the last 12 months.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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. The 2013 -2014 QOF data for this practice showed it was performing lower than national standards with a practice value of 86% compared with the national average of 94%. We saw that QOF data was regularly discussed at clinical meetings and action plans were produced to maintain or improve outcomes. For example, QOF data for 2013-2014 showed that the percentage of patients with a diagnosed mental illness who had an agreed care plan in place was 31.8% compared with the national average of 86%. We saw that the practice had increased the percentage to 77%. We also saw that the percentage of patients whose notes recorded a smoking status in the preceding 12 months had increased from 89% to 96% which was above the national average of 95%.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw that an audit of the care patients with coeliac disease had been carried out to determine if all of these patients had received the appropriate immunisations and annual blood tests. Coeliac disease is a digestive condition where a person has an adverse reaction to gluten. We saw that following the audit, action plans were put in place to ensure that more patients received this care and treatment. This included increased training for nurses and letters were sent to patients inviting them for these tests and immunisations. Another audit was carried out following these changes which demonstrated that the changes made were starting to have an impact on the number of patients receiving this care.

The practice had arrangements for identifying, recording and managing risks. However, there was no overarching risk log to ensure that identified risks were monitored and rated and mitigating actions recorded to reduce and manage the risk.

Leadership, openness and transparency

Practice meetings were only held twice a year however we saw that monthly practice nurse meetings took place and GP meetings more regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and health and safety which were in place to support staff. We were shown the staff

Are services well-led?

Good

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

handbook that was available for all staff which included sections on equality and diversity, whistleblowing and harassment and bullying at work. The handbook was readily available for all staff to access.

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.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through surveys, complaints received and their 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 three GP partners showed us the results of a patient survey of their individual practice. This looked at patient feedback in areas such as politeness, listening to patients and involving patients in decisions about their care. We saw that the three GPs had scored higher in all areas of patient satisfaction in comparison with the General Medical Council average.

The practice had an active PPG with a core group membership of seven patients between the age of 65 and 84 years old. The PPG met on a monthly basis and minutes of their meetings were available on the practice's website. We spoke with the chair of the PPG who told us that the practice listened to their views and acted on them. For example, we saw that at the suggestion of the PPG, artwork had been displayed on the walls in the practice and that a bird table had been put outside one of the windows. This provided a more welcoming and relaxed environment.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that GPs and administrative staff had received regular appraisals. However, one of the practice nurses told us they had not received an appraisal in six years. They told us that there were plans for their appraisal to be carried out but a date had not yet been set.

In August 2011 the practice had developed a practice development plan for the service which identified the risks to the practice, their strengths and what changes needed to be made to meet the needs of their patients. It also included an analysis of staff training needs and set time scales for the development of new services such as a diabetic process map. It was evident through discussions with the GPs that they were exploring ways of improving their service, for example, seven day working. However, the practice development plan had not been updated to reflect this.

The practice had completed reviews of significant events and other incidents and shared the learning with staff through emails and occasional staff meetings. For example, changes had been made to the process of issuing repeat prescriptions following an incident involving a patient who had ordered repeat prescriptions too often.