Dr A Sinha and Dr G De (Laceby Surgery)

Quality Report

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Date of inspection visit: 26 & 27 January 2015
Date of publication: 25/06/2015

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 Dr Sinha and Dr De (Laceby Surgery) on 26 and 27 January 2015.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services that were well-led and met the needs of the population it served.

The practice was outstanding for the care of older people.

Our key findings were as follows:

- Patients who used 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 an area of outstanding practice:

- The practice employed a care co-ordinator whose role was to review and co-ordinate the care of older people and to signpost them to available services when needed. This was to ensure they had a care plan in place and were receiving care and treatment which

Summary of findings

would reduce the risk of unplanned admissions to hospital. There had been an improvement in the rate of unplanned admissions from 339 in 2013/14 to 291 in 2014/15.

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

Importantly the provider should:

- Ensure records are kept to confirm vaccines were maintained at the required temperature when being transported between practice sites.

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 14 out of 20 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 higher than others in the local CCG area 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 which supported continuity of care. Urgent appointments were available on the same day requested. 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. 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. These patients had on-going reviews every three months or sooner if necessary.

The practice employed a care co-ordinator whose role was to review and co-ordinate the care of older people and to signpost them to available services when needed. 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. There had been an improvement in the rate of unplanned admissions from 339 in 2013/14 to 291 in 2014/15.

Each patient over 70 received a 'Happy Birthday' letter each year offering them a review by the practice; any chronic diseases were reviewed at this visit..

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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.

Summary of findings

The practice was working with the local advanced community care team on a pilot scheme looking at patients with complex chronic disease needs who were at higher risk of admission or attendance at the hospital.

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.

New mums were offered a six week post natal face to face appointment along with the baby check.

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. On-line access was available for patients to book appointments and to order repeat prescriptions. Late night clinics were available one evening a week. Patients were contacted on the telephone to discuss results, medication and to offer advice after normal working hours.

A full range of health promotion and screening was available that reflected the needs of this population 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 offered patients on the practice learning disability register an annual health check. 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 people with carer responsibilities.

The practice provided a substance misuse service to vulnerable patients. The service was GP led and had the support of a counsellor and nursing staff. 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.

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 the practice performed above the local CCG average for the percentage of patients diagnosed with dementia that had received a face to face review in the previous 12 months. The practice was also in line with the local CCG average for documented care plans that had been completed for 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. 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 of the practice to complete. We received responses from 25 patients who 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 two patients during the inspection and they also confirmed that they had received very good care and attention and they felt that 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 111 patients had responded. Results showed that patients were generally positive about the service they received and the practice performed at or above the local CCG average in a number of areas. For example:

- 87% of patients said it was easy to get through to the practice on the phone - CCG local average: 75%
- 84% of respondents describe their experience of making an appointment as good – CCG local average: 76%
- 90% of respondents find receptionists at this surgery helpful – CCG average: 88%
- 89% of respondents describe their overall experience of this surgery as good – CCG local average: 86**%**
- 81% of respondents would recommend this surgery to someone new to the area - CCG local average: 79%

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.

Areas for improvement

Action the service SHOULD take to improve

Ensure records are kept to confirm vaccines were maintained at the required temperature when being transported between practice sites.

Outstanding practice

We saw an area of outstanding practice:

- The practice employed a care co-ordinator whose role was to review and co-ordinate the care of older people and to signpost them to available services when needed. 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. There had been an improvement in the rate of unplanned admissions from 339 in 2013/14 to 291 in 2014/15.

Dr A Sinha and Dr G De (Laceby Surgery)

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr A Sinha and Dr G De (Laceby Surgery)

The Laceby surgery is situated in Laceby Village 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 Laceby village and Grimsby area. Dr Sinha & Dr De provide services to 4220 patients of all ages at Laceby village and also at Cromwell Road in Grimsby. There is a significantly higher percentage of the practice population in the 65 to 84 years age group and a slightly lower percentage in the 85 and over age group than the England average. The percentage of the practice population in the under 18 age group was the same as the England average. The overall practice deprivation score is slightly higher than the England average, the practice is 24.1 and the England average is 23.6.

The practice has two GP partners, both male and one locum female GP who does regular sessions at the practice. There are two practice nurses and two health care assistants (HCA). There is one practice manager and a team of reception and administrative 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 patients use the 111 service. 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:

Detailed findings

- 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 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 the 26 and 27 January 2015.

During our visit we spoke with a range of staff including a GP, the practice nurse, a receptionist and the practice manager. We spoke with two 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 25 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 test result had been given to the wrong patient as they had the same name as the patient who had the test.

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.

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 monthly clinical meetings and the monthly practice meetings, which all staff attended. 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 shared electronic folder 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 contacting patients to give them test results. Staff now confirmed a patient's date of birth with them as well as their name to reduce the risk of the test result been given to the wrong patient.

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, 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.

Good

Are services safe?

There was a chaperone policy and information informing patients that they could ask for a chaperone was visible in the waiting room and 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. Staff who chaperoned had received training. One patient we spoke with told us they had been asked if they wanted a chaperone.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear procedure for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure. The nurse described the action they had taken in response to an incident when one of the fridges had broken, to ensure vaccines were not used.

Vaccines, which had to be kept at a cool temperature, were transported to Laceby surgery in a specially designed container and staff told us they checked that the required temperature had been maintained during transport. However no records were kept to confirm the length of time the vaccines were in the container and that the required temperature had been maintained.

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

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

There was a system 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.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept secure at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, the number of patients being prescribed hypnotic medicines had been reviewed after it was identified that the practice was a high prescriber of these medicines. There had been no increase in the number of patients who were prescribed these medicines during 2014. The GP told us the high prescribing rate was attributed to the substance misuse service that the practice provided, however the practice had not undertaken an audit to confirm that they were prescribing appropriately for all the patients.

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 regular updates.

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 and 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. Hand wash; disposable towels and hand gel dispensers were also 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 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.

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

There were systems in place 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 regular checks were carried out 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. 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 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. We saw evidence that maintenance was undertaken as required. There was a process in place for staff to report any faults or problems and they confirmed that issues were dealt with in a timely manner.

The practice had a health and safety 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.

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 airway equipment and oxygen was available and emergency medicines, including those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not have an automated external defibrillator (used to attempt to restart a person's

Good

Are services safe?

heart in an emergency). The practice had assessed the risks and decided this was not required as ambulances responded quickly in the event of an emergency. The risk assessment had not been documented.

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, oxygen 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, 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.

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 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 and 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 nurses 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, family planning 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. After these patients were discharged from hospital the 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. We saw evidence that reviews of elective and urgent referrals were made, and that improvements to practice were shared with clinical staff.

Discrimination was avoided 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 undertaken16 audits in the previous year. Following each clinical audit, changes to treatment or care were made where needed. For example, the practice had done an audit in 2013 to determine if patients that had a heart condition called atrial fibrillation were being prescribed medication as recommended in the current clinical guidelines. The audit demonstrated that only 72.7% of patients were on the recommended medication. The audit was repeated in 2014 and results showed that 100% of patients were being prescribed medication as recommended in the current clinical guidelines.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for

Good

Are services effective?

(for example, treatment is effective)

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, we saw an audit had been completed regarding the prescribing of analgesic (painkiller) patches. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their practice so they were prescribing in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 85% of patients with chronic obstructive pulmonary disease (lung disease) had been reviewed within the previous 12 months; this was in line with the local CCG average. QOF data for 2013/2014 showed the practice was performing above the CCG average for 14 of the 20 clinical indicators including asthma, diabetes 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 implemented the gold standards framework for end of life care. 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 benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example rates for emergency admissions to hospital.

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, infection control and safeguarding children and adults. The training matrix outlined what training each member of staff had attended however it did not identify if any refresher training was required and at what intervals this should occur.

We noted a good skill mix among the doctors with three having additional qualifications, for example in diabetes, contraception, palliative care and substance misuse. All GPs were up to date with their yearly continuing professional development requirements and had either 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 one nurse was doing a minor illness course. 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.

Good

Are services effective?

(for example, treatment is effective)

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.

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 or nurse who requested the test or investigation was responsible for reviewing their own results and following an incident the practice had amended its procedure so that if they were on holiday the results were sent to the 'duty doctor' for that day. The GP or nurse 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 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 month 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, health visitors and 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.

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.

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 this was fully operational. (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 system 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.

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).

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's 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 a member of clinical staff. 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 depression screening to patients with long term conditions 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.

QOF data for 2013/2014 showed the practice had identified the smoking status of 89.7% of patients over the age of 15 (this was in line with the local CCG average), 98.9% of these patients had been offered support and treatment within the preceding 12 twelve months (this was above the local CCG average). Also the practice had recorded the smoking status of 97% of patients with chronic diseases such as heart disease, diabetes and those with mental health conditions and 98.9% had a record of an offer of support and treatment recorded in their records within the preceding 12 months. This was above the local CCG average. 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 was 81.4%, which was in line with others in the CCG area. There was a policy to offer 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 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 if appropriate was 82.1%, this was 4% below the local CCG average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data for immunisations was similar or above the CCG average for children aged 24 months and 5 years and below the CCG average for immunisations for children aged 12 months. 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 111 respondents and responses from the friends and family test. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 85% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern and 91% said the GP was good at listening to them. The local CCG average for these two areas was 84% and 91% respectively. The satisfaction rates for the nurses for both these areas were 97% and the local CCG average was 92% and 93% respectively.

Patients were also positive about their overall experience of the practice with 89% saying their overall experience of the surgery was good and 81% saying they would recommend the surgery to someone new to the area. The local CCG average was 86% and 79% respectively.

We received 25 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 desk was located away from the waiting room and had a glass window which was closed when staff were talking on the telephone, reducing the risk that confidential conversations would be overheard. We saw there was a sign asking patients to stand back from the reception desk until it was their turn to speak with the receptionist. A room was available if patients wished to discuss a matter with the reception staff in private, however there was no notice informing patients of this.

We observed reception staff treating patients with respect and being extremely tactful when dealing with requests. Data from the national patient survey 2014 showed 90% of respondents found the reception staff helpful, the local CCG average was 88%.

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 82% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results, the local CCG average was 78% and 85%. The satisfaction rates for the nurses for these two areas were 93% and 98% respectively the local CCG average was 87% and 91%.

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.

Staff told us that translation services were available for patients who did not have English as a first language. There were notices in the reception area informing patients about the translation service. Google translate was available on the practice website.

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

Good

Are services caring?

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.

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. Carer's packs were available in the waiting areas and the practice sent a pack to any patients identified as a carer.

Patients receiving end of life and palliative care were well supported by the GPs and nurses in the practice.

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, for patients over the age of 75 there was a care co-ordinator who reviewed care, co-ordinated and sign posted patients to all available services.

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. One of the GPs was a member of the CCG Council of Members and the practice manager attended the local practice manager forum meetings.

The practice was participating in the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. For example the practice had established a register of their patients at risk of unplanned admissions. Each patient had had a care plan developed and agreed with the GP, other services involved in their care, and if relevant their carer. There was a recall system so all patients were regularly reviewed. There had been an improvement in the rate of unplanned admissions from 339 in 2013/14 to 291 in 2014/15.

The duty doctor would review the discharge summaries for all patients who had an unplanned hospital admission to identify any actions required, for example medication reviews. The practice would aim to contact patients within three days of discharge to confirm that all their needs were being met and if necessary arrange support.

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 after suggestions from patients a consulting room that was no longer used was converted into a waiting area in 2014. The waiting area was then located away from the reception desk and had improved confidentiality.

Also in February 2014 patients had asked if the prescription request telephone line could be open for longer. There was now a dedicated phone line for patients to order repeat prescriptions which was facilitated by the 360 care group. The 360 care group consisted of seven local practices that had joined together to provide some services that were commissioned by the local CCG and pool training resources. For example there was an ultrasound service provided from the Cromwell Road health centre which patients could be referred to which reduced the need for them to travel to the hospital.

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. Staff had completed learning disability awareness training. 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 practice was accessible to patients with mobility difficulties as it was all on one level. 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. There were two clinics each week at the Cromwell Road site which were supported by a GP, a counsellor and nursing staff. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 6.30pm Monday, Tuesday, Thursday and Friday and 8.00am to 12.00pm on Wednesday. The other practice site at Cromwell Road was open on Wednesday afternoons and all patients could access care there. The Laceby surgery offered late night appointments until 7.30pm on Thursdays. 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.

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 84% of patients described their experience of making an appointment as good; the local CCG average was 76%. Reception staff told us they felt the system worked well and they felt they could always offer patients an appointment. Patients could register to have text messages sent to remind them of their appointments.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. An alert was placed on patient's records to alert staff if patients had a learning disability or a hearing problem. Reception were then able to book longer appointments for these patients. 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 nurses provided telephone triage each day to assess patients' needs and direct them to the most appropriate clinician or service. 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, by telephone 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 but the timescales they would receive a response by was not clear.

We saw that information was available to help patients understand the complaints system. There was a summary in the waiting room and details on the practice website. Information was also available on the local Patient Advice and Liaison Service (PALS). This is a confidential advice and support service which can provide advice and information on local NHS services and also help to sort out any problems on behalf of patients. 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 16 complaints in the previous 12 months. 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 identified areas for

Good

Are services responsive to people's needs?

(for example, to feedback?)

improvement following complaints, for example customer care training had been provided and the referral protocol had been amended following a complaint about a patient's referral to hospital.

We saw that the practice had received 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 their 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 providing high quality health services to their patients; ensuring prompt and efficient access to services by the most appropriate professional and in the most appropriate setting; to improve the co-ordination of health and social care services in order to provide a seamless service for patients; to develop a flexible workforce that would address the current and future needs of patients and to support the training and development of newly qualified doctors within general practice. 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 eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at 12 of these policies and procedures and saw they had been reviewed at least 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 average for 14 of the 20 clinical 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 review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice discussed incidents and complaints at practice meetings and clearly documented the findings of investigations. However there was no regular review to confirm that actions had been completed.

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.

The practice had completed clinical audits which it used to monitor quality and to identify where action should be taken. For example the practice was had undertaken an audit 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

Meetings were held 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 process in

Are services well-led?

Good

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

place and there were policies or procedures for 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. One of the GPs had completed training in clinical leadership.

The GPs and practice manager had invested a lot of time over the previous 18 months implementing new procedures and policies and developing the use of the electronic patient record system. This had improved the way staff in the practice communicated with each other and people external to the practice. For example practice staff now sent an electronic message to the health visitor team if a child did not attend for an immunisation appointment. The practice had achieved the Quality in Practice Award in June 2014.

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 which met quarterly. There was information on the practice website and in the waiting room encouraging patients to become involved in the PPG. 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. The PPG was working to increase the size of the group and they had suggested displaying the meeting minutes on notice boards in the waiting room and holding 'drop in' sessions. Minutes were displayed for patients to see and drop in sessions had been held during 2014.

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. Following the survey the afternoon appointment system had been changed so that it was not a 'walk in' service and patients now had to book an appointment. This had improved waiting times for patients. 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 in the reception area 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 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 were doing the minor illness course.

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 incident when an abnormal specimen result had not been actioned when a nurse was on leave a new procedure was introduced so test results were re-directed if a member of staff was absent.