

# Aelfgar Surgery

## Quality Report

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

### Ratings

#### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected this service on 8 April 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients told us they were able to book appointments when required. However, other patients told us it was difficult to contact the practice by telephone, and often when they got through, all of the same day appointments had been taken.
- The practice offered a range of in house services for patients, for example ultrasounds, community hearing care services and psychological therapies.
- There were inter-practice arrangements in place to provide services to patients registered with other GP practices in the locality.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

# Summary of findings

- Ensure all required recruitment checks are undertaken and kept in the relevant staff file.
- Clarify the safeguarding leads within the practice and ensure all staff are made aware.
- Ensure a system is in place to check the professional registration of the clinical staff is in date to ensure they are fit to practice.
- Introduce a system for identifying, responding to, managing and reviewing risks to patients and the service.
- Introduce a system to record and review all complaints.
- Review the access to and availability of appointments.
- Ensure policies and procedures are regularly reviewed and updated.

**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?

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events. 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. The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However, the practice had not systematically identified risks and recorded these in a risk log. There were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff worked with other health care professionals to improve patient outcomes. Regular multi-disciplinary meetings were held and the practice had identified the need to improve the recording of discussions and agreed actions. Staff had received training appropriate to their roles and any further training needs had been identified and planned for to meet these needs. There was evidence of appraisals and personal development plans for staff. Effective systems were in place in respect of information sharing with other services and promoting health promotion and prevention.

Good



### Are services caring?

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. They described staff as being friendly, caring and helpful. This was reflected in the data we looked at which showed positive patient feedback in relation to involvement in decisions about their care and treatment. The practice had good systems in place to support carers and patients to cope emotionally with their health and condition. Information to help patients understand the services available was easy to understand.

We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality. Views of external stakeholders such as care home managers were positive and aligned with our findings.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients' views varied on access to a GP. Most patients told us they were able to book appointments when required. Other patients told us it was difficult to contact the practice when it opened by telephone, and often when they got through, all of the same day appointments had been taken. 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. However, for completeness informal complaints should also be recorded.

Good



## Are services well-led?

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 and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



# 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

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was participating in the Frail Elderly Project, which identified the most vulnerable patients in the older population who required additional support. It was responsive to the needs of older people and offered home visits as required. The practice identified if patients were also carers, and information about support groups was available in the waiting room.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. Longer appointments and home visits were available when needed. All of these patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

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 who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Appointments were available outside of school hours and the premises were suitable for children and babies. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice. New mothers and babies were offered a six week check.

Good



### Working age people (including those recently retired and students)

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

Good



# Summary of findings

care. Although the practice did not offer extended hours, there were 'worker' appointments available towards the end of the afternoon surgery. The practice offered all patients aged 40 to 75 years old a health check with the nursing team. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence or of no fixed abode. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Good



## People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice could refer patients directly to the mental health crisis team or community mental health team. The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place. Information about how to access mental health services was available in the waiting areas.

Good



# Summary of findings

## What people who use the service say

We spoke with nine patients on the day of the inspection. Patients were mostly satisfied with the service they received at the practice. They told us that clinical staff treated them with care and concern. Patients told us the system for pre-bookable appointments worked well. However, three of the patients spoken with commented that it was more difficult to book a same day appointment as the telephone lines were busy at 8.30am and often the appointments had all be taken by the time their call was answered.

We reviewed the 59 patient comments cards from our Care Quality Commission (CQC) comments box. We saw that the majority of comments were positive. Patients said they felt the practice offered a good service and staff were helpful, caring and professional. They said staff generally treated them with dignity and respect. Nine patients made comments that were less positive. These all related to the telephone booking system for appointments.

We looked at the practice's own patient survey which showed that 73% of patients said they were very satisfied

or quite satisfied with the availability of emergency appointments on the same day. When asked if patients found it relatively easy to get an appointment with a doctor of choice in a reasonable time period, 35% said they found it easy and 55% said sometimes it was a problem. The practice's action plan included offering more online appointments and advertising the system more widely including on the patient call system.

We looked at the NHS Friends and Family Test results for January and February 2015. The results for January 2015 showed that 142 out of 158 patients said they were extremely likely or likely to recommend that practice and for February it was 10 out of 10 patients. All nine patients spoken with during the inspection said they would recommend the practice to someone new to the area.

We looked at the national patient survey published in January 2015. The survey found that 93% of patients described their experience of the practice as good. The results showed that 89% of patients would recommend the practice to someone new to the area, which has higher the Clinical Commissioning Group average of 78%.

## Areas for improvement

### Action the service SHOULD take to improve

Ensure all required recruitment checks are undertaken and kept in the relevant staff file.

Clarify the safeguarding leads within the practice and ensure all staff are made aware.

Ensure a system is in place to check the professional registration of the clinical staff is in date to ensure they are fit to practice.

Introduce a system for identifying, responding to, managing and reviewing risks to patients and the service.

Introduce a system to record and review all complaints.

Review the access to and availability of appointments.

Ensure policies and procedures are regularly reviewed and updated.

# Aelfgar Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a Care Quality Commission lead inspector. The lead inspector was accompanied by a GP specialist advisor and an expert by experience who had personal experience of using primary medical services.

## Background to Aelfgar Surgery

Aelfgar Surgery is located in the centre of Rugeley, Staffordshire. The practice provides services to people who live in Rugeley, Brereton, Etching Hill, Colwich, Little Haywood, Armitage, Handsacre, Longdon and Upper Longdon.

The practice has two GP Partners and a salaried GP (one male and two females), a practice manager (who is also a business partner), a nurse practitioner, two practice nurses, two healthcare assistants and reception staff. There are 4890 patients registered with the practice. The practice is open from 8am to 6.30pm Monday to Friday. The practice treats patients of all ages and provides a range of medical services. Aelfgar Surgery has a higher percentage of its practice population in the 65 and over age group than the national average.

The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice also provides placements for Foundation Doctors (these are newly qualified doctors who are gaining a few months supervised general practice experience).

The practice provides a number of clinics for example long term condition management including asthma, diabetes and high blood pressure. It offers antenatal care, child immunisations and travel health.

Aelfgar Surgery has a contract to provide Personal Medical Services. The practice may deliver services to the local community beyond the General Medical Services (GMS) contract.

Aelfgar Surgery has opted out of providing an out-of-hours service to its patients but it has alternative arrangements for patients to be seen when the practice is closed. The out of hours service provider has recently changed and from April 2015 has been provided by Staffordshire Doctors Urgent Care.

## 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 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

# Detailed findings

## How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included Cannock Chase Clinical Commissioning Group, Healthwatch and NHS England Local Area Team.

We carried out an announced visit on 8 April 2015. During our inspection we spoke with two GPs, a registrar, a practice nurse, a health care assistant, the practice manager and reception staff. We spoke with nine patients who used the service about their experiences of the care they received. We reviewed 59 patient comment cards sharing their views and experiences of the practice. We also spoke with representatives from two local care homes who worked with the practice.

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

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

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

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

# 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. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place. The practice nurse described an incident that they had recently reported relating to the recent change in the supplier of diabetic needles. They told us this had been discussed within the practice and they had been supported to report this externally to the diabetic nurse specialist.

We saw there were safety records and incident reports for 12 months. 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 previous 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and the outcome. One incident related to being unable to gain access to the home for a patient who had requested a home visit. The other related to a false negative result for a patient with a potentially

contagious disease. We saw that the incident forms recorded the analysis of the incident, action plan and follow up and that the incident had been discussed at the clinical meeting.

National patient safety alerts were disseminated by the practice manager to practice staff. Nursing staff told us they were responsible for acting on any alerts relevant to their area of care, although the practice pharmacist dealt with any alerts relating to medicines. They told us there was a system in place to inform the senior partner when the required action had been taken.

### 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 which showed that staff had received relevant role specific training on safeguarding. We asked members of clinical and reception staff about their training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children who could demonstrate that they had the necessary training to enable them to fulfil this role. However, there was confusion amongst the staff about which GP was the safeguarding lead, and the information was not clearly recorded in the practice policies. The senior partner provided an example of when they had appropriately raised safeguarding concerns with the local safeguarding team.

There was a chaperone policy which was advertised in the waiting room. (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). Members of the nursing team and reception staff acted as chaperones. The health care assistants and reception staff had received appropriate training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination and what to do if they had any concerns regarding the examination. Patients spoken to told us they were offered a chaperone.

## Are services safe?

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or in the care of the local authority and patients with learning disabilities. There was a system in place that highlighted patients with caring responsibilities. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us they had a very good working relationship with the health visitor attached to the practice and there were systems in place to share information of concern.

### 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. We found that practice staff followed the policy.

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

The nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role from the senior partner.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions

were still appropriate and necessary. Any changes to medicines requested by either the hospital or the patient were reviewed by the GPs before the prescription was issued.

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. The practice had established a service for patients to collect their prepared prescriptions at a number of locations. The practice also offered the electronic prescription service, where electronic prescriptions were sent directly to the pharmacy removing the need to collect the paper prescriptions from the practice.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice employed a prescribing pharmacist one day a week to provide support with medicines management. This member of staff advised the practice of any changes in guidance and carried out searches to identify patients on medicines where the guidance had changed. They were also responsible for reviewing patients with asthma, and carrying out medicine reviews for patients, including those who lived in care homes. We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing.

### 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.

The nurse practitioner was the lead for infection control within the practice. We saw that all staff had received in house training about infection control specific to their role. The training was updated every three years and training records indicated when the next training was due. An infection control audit had been carried out in November 2014 by the local NHS community trust. The practice achieved an overall score of 93%.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan

## Are services safe?

and implement measures to control infection. For example, personal protective equipment including disposable gloves and aprons were available for staff to use. Spillage kits were available to manage any spillage of bodily fluids.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that clinical staff had received appropriate immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

The practice had a risk assessment that covered the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The risk assessment had been completed in November 2013 and included a number of recommendations. The practice manager was unsure whether the recommendations had been addressed or not. The practice did not carry out regular checks in line with the risk assessment to reduce the risk of infection to staff and patients.

### Equipment

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

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at a staff file for a newly recruited member of reception staff. Records we looked at contained evidence that although appropriate recruitment checks had been undertaken prior to employment, they

were not all on file. For example, proof of identification including a recent photograph and information about any physical or mental health conditions. We saw from the completed recruitment checklist that these checks had been obtained or requested but not placed on file. In addition the application form did not ask for a full employment history.

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. They 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 minimum number of reception staff on duty during the day, and we were told that staff would cover sickness and holidays. The number of practice nurse hours had been increased during 2014 following audits which demonstrated an increase in hours was required. The practice manager told us about the arrangements for planning and monitoring the number of nursing staff and mix of staff needed to meet patients' needs. There was one part time advanced nurse practitioner (20 hours a week), two part time practice nurses (35.5 hours a week) and two part time health care assistants (60 hours a week). The practice manager told us that the team was able to cover annual leave.

### Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing and dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice had not identified all risks and recorded these in a risk log. The practice manager told us they carried out opportunistic risk assessments, for example for a member of staff who was pregnant. A fire risk assessment had been completed and was stored in the fire proof safe. There was some evidence that risks were discussed at the clinical meetings. For example, the advanced nurse practitioner had shared the recent findings from an infection control audit with the team.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received

## Are services safe?

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (A portable electronic device that analyses life threatening irregularities of the heart including ventricular 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 regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. The practice did not routinely hold stocks of medicines for the treatment of meningitis. The GPs told us they had considered this and felt it was appropriate to call 999 and request an emergency

ambulance if they suspected this condition. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of 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 power failure, adverse weather and access to the building. The document also contained relevant contact details for staff to refer to. Copies of the business continuity plan were kept off site with each of the partners.

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 awareness training and they had practised fire drills.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The practice nurse we spoke with told us that they were made aware of any new guidance and it was discussed within the clinical meetings. 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 lead in specialist clinical areas such as diabetes, heart disease, family planning and end of life care and the nurses and prescribing pharmacist 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.

We saw in the clinical meeting minutes that the local Clinical Commissioning Group (CCG) benchmarked the practice against other practices in the locality for the use of antibiotics. The use of antibiotics was discussed during the meeting as well as the action for staff to take.

### 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 and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice used the electronic system to alert clinical staff to collect QOF data

when patients attended for a consultation or a home visit was carried out. The practice achieved 99.1% QOF points out of a possible 100%, which was above the national average. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The practice offered all aspects of the Avoiding Unplanned Admissions enhanced service. This is where the practice identified the most vulnerable patients and developed care plans to assist with avoiding admission to hospital. The practice told us there was an overlap of these patients with those identified as part of the Frail Elderly Project.

The practice showed us five clinical audits that had been undertaken in the last three years. One of the audits was at two cycle audit on the use of antidepressants in the elderly. However, one audit we looked at was not dated, did not name the author and had no clear suggested actions. The practice undertook ongoing quality improvement using alerts linked to QOF data within the electronic patient note system. However, there was no evidence of this in the minutes of the clinical meetings. The practice also received information from the CCG, who ran quality data reports which were discussed at practice meetings, for example prescribing data. This information was used to review staff practice and make appropriate changes.

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 / prescribing pharmacist. The practice pharmacist flagged up relevant medicine alerts and identified patients on the particular medicine. The practice also used an electronic system that supported cost effective prescribing, taking into account national guidance and local prescribing choices.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix amongst the partners, with one having an additional diploma in sexual and reproductive medicine, and both carrying out joint injections and cryotherapy (using very low temperatures to treat conditions such as warts and moles). All GPs were up to date with their yearly continuing professional development requirements and all

# Are services effective?

## (for example, treatment is effective)

either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice did not have a system in place to check that clinical staff registrations with their professional bodies were in date. The practice manager was shown how to check the nurses' registrations with their professional body, and checked these during the inspection. The practice manager was advised to check that the salaried GP was registered on the performers list.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There was protected learning time each month, with each section of staff attending training relevant to their role. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

The nursing team were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical smears, and smoking cessation. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma and diabetes were able to demonstrate that they had appropriate training to fulfil these roles. Each nurse had a lead role for long term conditions and were supported by the GPs with the management of these patients.

### 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. The GP who saw these documents and results was responsible for the action required. All staff we

spoke with understood their roles and felt the system in place worked well. There had been an incident during January 2015 where an urgent scan result had been faxed through the practice but not placed in the GP tray for review. This was reported and investigated as a significant event.

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 the lead GP, district nurses and palliative care nurses. All patients on the palliative care register were reviewed at these meetings, and any additional care requirements discussed. 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 had been a shared system with the local GP out of hours provider to enable patient data to be shared in a secure and timely manner. The practice was in discussion with the new out of hours provider about so that relevant information could be shared with them. The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them.

The practice had signed up to the electronic Summary Care Record (SCR). (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information about the electronic SCR was included on the practice website.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

We saw that the practice had policies and guidance on consent, the Mental Capacity Act 2005, and the assessment of Gillick competency of children and young adults. A

# Are services effective?

## (for example, treatment is effective)

Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

The GPs had received training on the Mental Capacity Act 2005 as part of their protected learning time. However the nurses and health care assistants had not received any training, although the practice nurse told us they had received dementia awareness training. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. There was a system in place to alert staff to ask a number of questions to assess a patient's memory. Nursing staff spoken with told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment.

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

Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt cardiopulmonary resuscitation' (DNACPR) care plans. They told us the appropriate paperwork was completed and scanned on to the electronic system. The staff representatives from two of the care homes told us that GPs discussed end of life care and the DNACPR care plans with the patient and their families.

### Health promotion and prevention

The practice attended Clinical Commissioning Group locality meetings to review and discuss best practice and develop new initiatives. They worked closely with other practices in the area to provide a range of services, for example contraceptive implants and coil insertions.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP / practice nurses were informed of all health concerns detected and these were followed up in a

timely way. One patient commented positively about the new patient health check on their comment card. They said they had been able to discuss their concerns and these had been dealt with in a caring professional manner.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, in house smoking cessation programmes and referrals to weight loss services for weight management. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The nursing staff told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They had a range of leaflets available to give to patients, and leaflets were also available in the waiting room. Information relating to health promotion and services was displayed on the television screen in the waiting room.

The practice offered sexual health and family planning advice and support, including emergency contraception. Chlamydia screening was available for patients aged 16 to 24 years, and the testing kits were available for patients to take away. There was a system in place to alert staff to offer chlamydia screening to patients up to the age of 24 years when they attended the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the average for the CCG, and there was a clear policy for following up non-attenders.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were invited by letter to attend for a 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 these patients were offered an annual physical health check. The practice had offered smoking cessation advice to 3.8% of patients identified as current smokers. There was evidence this were having some success as 36% of those patients seen by the smoking cessation advisor had stopped smoking in the last 12 months. One patient commented on their comment card that the practice had supported them to stop smoking. The practice's performance for cervical

## Are services effective?

(for example, treatment is effective)

smear uptake was 77%, which was slightly below the national target of 80%. There was a policy to send reminders for patients who did not attend for cervical smears.

# 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 121 replies to the national patient survey published January 2015, a survey of 110 patients undertaken by the practice, and the NHS Friends and Family Test for January and February 2015. The practice also received comments from the virtual patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was generally with compassion, dignity and respect. For example, data from the national patient survey showed that 93% of practice respondents rated their overall experience of the practice as good. The survey showed that 98% of respondents felt that the doctor was good at listening to them and gave them enough time. Both of these results were above the local Clinical Commissioning Group (CCG) average of 85%. The results were similar for the nurses, with 97% of respondents felt that the nurse was good at listening to them, and 95% said the nurse gave them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 59 completed cards and were very positive about the service experienced. Patients said they felt the practice offered a good service and staff were professional, helpful and caring. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and 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. We saw that due to the layout of the building, confidentiality was

difficult to maintain. The practice had made efforts to minimise any risk by placing background music in the waiting room. The waiting room was small so conversations between patients and staff could easily be overheard. Seven of the nine patients spoken with commented that conversations could be overheard but did not express any concerns about their privacy or confidentiality. They were not unduly concerned. Reception staff told us that if a patient wished to speak with them confidentially, they would take them into a separate room. There was information in the waiting room to inform patients about this.

We saw that any concerns regarding staff or patient behaviour were addressed by the practice manager. There was a system in place to record information relating to staff or patients' behaviour. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Nursing staff and receptionists had received training on skills required to help them diffuse potentially difficult situations.

### Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff. Patients' comments on the comment cards we received were also positive and supported these views.

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 86% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 88% of practice respondents said the nurse involved them in care decisions and 93% felt the nurse was good at explaining treatment and results.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us they had access to a language line to help with consultations with patients where English was not their first language.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or

## Are services caring?

who had additional needs due to their medical condition. For example, those with mental health difficulties or dementia, learning disabilities, complex health needs or end of life care. The practice was part of local initiative to identify frail elderly patients, and individual care plans had been developed and agreed for these patients. We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma.

### **Patient/carer support to cope emotionally with care and treatment**

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 89% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern with a score of 96% for nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Leaflets in the patient waiting rooms and on the website told people how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was also a carer. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. The practice offered all carers a seasonal 'flu vaccination. The senior partner told us the practice had good links with the local carers association and actively discussed with carers what other support they may need.

The Citizen's Advice Bureau (CAB) held weekly sessions at the practice. The CAB assisted patients to access benefits and support that they were entitled to. A representative from social services also visited the practice weekly, to discuss any patients or families that may require additional support. Chase Emotional Well-being service provided psychological support for patients registered at this and other local GP practices, with sessions held at the practice.

# 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 practice offered a range of enhanced services, for example invasive minor surgery and coil and implant fitting and travel vaccinations including yellow fever. The practice also provided a range of clinics for the management of long term conditions, such as asthma, chronic obstructive airways disease (COPD), heart disease and diabetes. The practice worked collaboratively with other practices in the locality to offer services such as coil and implant fitting and joint injections to patients registered elsewhere.

The needs of the practice population were understood and systems were in place to address identified needs. As part of an enhanced service the practice had identified patients most at risk of unplanned hospital admissions and had developed individual care plans for patients. The prescribing pharmacist also reviewed all discharge letters for these patients to ensure they were on the correct medication.

The practice actively engaged in Clinical Commissioning Group (CCG) projects. The practice was a pilot practice for the 'Frail Elderly Project', a project aimed at identifying the most vulnerable patients in the older population who require additional support. Those patients identified with increasing needs were seen by a GP and detailed care plan developed in agreement with the patient. A copy of the care plan was left with the patient to inform other health professionals of the issues and wishes for care that the patient had.

The practice engaged with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. For example, the senior partner attended locality meetings and was due to take on the role of Chairperson at the beginning of June 2015. The practice manager attended the practice manager locality meeting. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. There were also inter-practice arrangements with the other practices in the CCG locality which enabled patients to receive services within their community.

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). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Following comments from the PPG and patient survey, the practice promoted on line booking for appointments and monitored its use to assess demand.

We spoke with representatives from two local care homes. They told us they worked in partnership with the practice to meet the needs of the patients and spoke highly of the GPs. They told us the practice was very responsive and the GPs always visited on request. They said that the GPs involved the patients and families in decision making around end of life care.

### Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, people passing through the town on narrow boats, patients with a learning disability and people accommodated at the local hostel. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member who would translate for them. Staff told us they had access to language line if required. There were two permanent female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice provided equality and diversity training through e-learning and training records supported staff had completed this training.

The premises and services were suitable to meet the needs of people with disabilities. All services for patients were situated on the ground floor. There was a hearing loop system available for patients with a hearing impairment.

# Are services responsive to people's needs?

## (for example, to feedback?)

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. There were automatic doors at the entrance to the building and to the corridor where the consultation rooms were situated, which made easy access for wheelchairs users and patients with pushchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

### Access to the service

The practice leaflet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments via the telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them. The contact telephone arrangements for the out of hours service was in the practice leaflet and on the website. Telephone calls made to the practice when it was closed were automatically diverted to the out of hours service.

The practice opened from 8am until 6.00pm, and appointments were available to be booked from 8.30am. The practice offered same day appointments, pre-bookable appointments and telephone triage. Same day and pre-bookable worker appointments were also available (late afternoon/ evening or early morning). Consultation times were from 9am until 11.30am, and 3pm until 5.30pm or 3.30pm until 6pm. Information about the working patterns of each doctor was displayed in the waiting room. The practice did not offer any extended hours.

Patients were generally satisfied with the appointments system. Patients told us the system for pre-bookable appointments worked well. However, three of the patients spoken with commented that it was more difficult to book a same day appointment as the telephone lines were busy at 8.30am and often the appointments had all be taken by the time their call was answered. These comments were similar to those made on nine out of the 59 comment cards. The data from the national GP survey also highlighted challenges getting through on the telephone. Ninety two percent of respondents stated that they were able to get an appointment last time they tried and 97%

said the last appointment they got was convenient. However only 72% of respondents found it easy to get through on the telephone, which was below the Clinical Commissioning Group average of 80%.

We looked at the practice's own patient survey which showed that 73% of patients said they were very satisfied or quite satisfied with the availability of emergency appointments on the same day. When asked if patients found it relatively easy to get an appointment with a doctor of choice in a reasonable time period, 35% said they found it easy and 55% said sometimes it was a problem. The practice's action plan included offering more online appointments and advertising the system more widely including on the patient call system.

As a result of comments made in the patient survey and feedback from the PPG, the practice had reviewed the capacity and booking patterns of appointments. Capacity had been increased by increasing the number of practice nurse appointments available. The practice had also participated in the Clinical Commissioning Group (CCG) audit of appointments during February 2015. The senior partner was due to reduce the number of sessions per week they worked at the practice, as they had been appointed as the Chair of the CCG. They were aware that this would reduce the number of appointments available and were considering how to address the shortfall.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice cared for patients in a number of local care homes. Home visits were made to the care homes on request, although the practice had recently introduced weekly visits to one local care home to carry out assessments and medication reviews on the patients who lived there.

The practice had access to a range of services to support patients with mental health needs. Patients could be referred to the Chase Emotional Well-being service, which provided psychological support for patients registered. The service held sessions held at the practice, which enabled patients to be seen in an environment they were familiar with. Patients could also be referred to the local NHS mental health services if required.

The practice was able to offer a limited number of appointments outside of school hours for children.

# Are services responsive to people's needs?

(for example, to feedback?)

Systems were in place to monitor mothers to be, from confirmation of pregnancy through to the six week post natal check. Family planning services were available, including implant and coil fitting.

## 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 made aware of how to complain through the practice leaflet and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure. One patient spoken with during the inspection told us they

had raised concerns informally with reception staff about how long they had waited to be seen. The practice did not have a system for recording verbal complaints made in this way.

We found that there was an open and transparent approach towards complaints. The practice had received two written complaints during 2014 – 2015. We saw that the practice recorded these complaints and actions were taken to resolve the complaint as far as possible. We saw that these had been handled satisfactorily and discussed with the relevant member of staff and the wider staff team where appropriate.

Due to the limited number of complaints received the practice did not maintain a complaints log. The practice reviewed the written complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified.

# 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. The aims of the practice were included in the statement of purpose. They were to provide the patients with personal health care of high quality and to seek continuous improvements in the health status of the population. It was clear when speaking with the GPs and the practice staff that they shared these aims and were committed to providing high quality care that met the needs of the practice population. Patients commented that they felt they received personalised care and support. Several patients commented that they felt listened to and concerns were always taken seriously.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and in paper form. Review dates were included in the policies. We saw that policies had been reviewed, although not all information had been updated, for example the change from Primary Care Trusts to Clinical Commissioning Groups.

On the whole 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 each of the GP partners had lead roles, including family planning and long term conditions. We spoke with a number of staff from different departments 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 held a Personal Medical Services (PMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is an incentive scheme which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing above the national average. We saw that QOF data was regularly discussed at the clinical staff meetings.

The practice had an ongoing programme of quality improvement and clinical audits which it used to monitor quality and systems to identify where action should be taken. For example: antibiotic prescribing and outcomes of referrals to secondary care.

The practice had some arrangements for identifying, recording and managing risks, although these need to be strengthened. The practice did not have a risk log to address a wide range of potential issues. Risk assessments had not been carried out where risks were identified or action plans produced and implemented.

### Leadership, openness and transparency

We saw that a range of staff meetings were held monthly. 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. We looked at the minutes from the various meetings. The meetings were used to discuss a range of topics, including ongoing monitoring of performance, delivery of enhanced services and feedback from any projects or local initiatives.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as the recruitment and selection policy which were in place to support staff. The policies were all stored electronically and in paper form and staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, comments and complaints and the Friends and Family Test. The practice was working with the virtual Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The patient experience survey highlighted issues around appointments and getting through on the telephone. The results of the survey and action plan were available on the practice website.

The practice gathered feedback from staff 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 that they had a good working relationship with the management.

# Are services well-led?

Good 

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

The practice had a whistleblowing policy which was available to all staff 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. They told us that they received an annual appraisal and there was a policy in place to support this. They confirmed the practice was very supportive of training and that they had monthly protected learning time.

The practice was able to evidence through discussion with the GPs, staff and practice manager and via documentation that there was a clear understanding among staff about safety and learning from incidents. We found that concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated, actioned and discussed at clinical meetings.

The senior GP partner was responsible for the induction and overseeing of the GP registrar's training. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a GP registrar who told us they felt well supported and secure in their role.

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. For example, the senior partner attended locality meetings and was due to take on the role of Chairperson at the beginning of June 2015. The practice manager attended the practice manager locality meeting. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. There were also inter-practice arrangements with the other practices in the CCG locality which enabled patients to receive services within their community.