Atherstone 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 10 February 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be rated as good in providing safe, effective, caring, responsive and well-led services. 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:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement within the practice.

The practice had a good track record to ensure a safe service was provided. Information 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 generally above average for the locality and the practice population. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' capacity to make decisions and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could show that all staff had received appraisals and had personal development plans. The practice was proactive and involved in research for the benefit of their patients. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. 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 and available in languages other than English. We also saw that staff treated patients with kindness and respect and maintained confidentiality. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us they could get an appointment with their preferred

Summary of findings

GP to ensure continuity of care. The practice offered a walk in service so that patients could be seen the same day for non urgent consultations. Urgent appointments were also made available the same day.

Information about how to complain was available and easy to understand and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy, although this would benefit from being formalised. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice promoted quality and caring as its top priority. All practice staff worked together to achieve this. Staff had attended staff meetings and events.

Patients told us that the practice was always supportive, caring and worked hard to make sure they met the healthcare needs of patients. The practice gathered feedback from patients through a patient participation group (PPG). The PPG consisted of patient volunteers who shared their views and responded to surveys. They commented about the services offered and how improvements could be made to benefit the practice and its patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people. The practice was also proactively screening patients over 75 years to check their fragility.

The practice offered home visits and fast access appointments for those patients with enhanced needs. GPs operated a patient list so that they got to know their patients and their health needs. Many of the patients had been with the practice for many years and had developed a trusting relationship with their GPs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed.

All patients had a named GP and a structured annual review was carried out to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk of harm, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

Appointments were available around school hours. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Child immunisations were carried out and there was a recall system in place to follow up where children had not received their appropriate vaccinations.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering on-line appointments and repeat prescription services, as well as a full range of health promotion and screening clinics that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. They carried out screening for patients identified at risk and advanced care planning for patients diagnosed with dementia.

Summary of findings

What people who use the service say

We reviewed 45 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all but five of these comment cards were extremely positive. Patients commented that they were impressed with the practice and that they could always see a GP when they needed to. The comments confirmed that GPs were always helpful and that they listened to concerns that patients had. Patients told us that they were really happy with all the staff at the practice and that everyone was courteous, helpful and polite. Patients also commented that they would not go anywhere else for their health care. They liked the open surgery option and told us that even though it was busy they knew they would always be seen by a GP.

Comments from five patients were not so positive. Three comments related to the dispensary service and included comments such as they felt there were not enough staff and that they had seen deterioration in the service. Two patients commented that although they could always see a GP, they had to wait some time to see their preferred GP.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated March 2014 and a survey of patients undertaken by the practice in 2014. The evidence from these sources showed patients were satisfied with the service they received, felt that they were given enough time and that they were treated with care and concern.

The practice was average for its satisfaction scores on consultations with GPs and nurses. Data showed that 77% were satisfied with appointment times, which was comparable with the national average of 78%; 81% described their experience of making an appointment as good compared with the national average of 78%; 82% would recommend this practice to someone new to the area which compared with national average of 79%.

Atherstone Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Nurse specialist advisor.

Background to Atherstone Surgery

Atherstone Surgery is located in Atherstone, North Warwickshire and provides primary medical services to patients. The practice covers Atherstone and the surrounding area, including Twycross, Sheepy Magna, Sheepy Parva, Wellsborough, Mancetter, Oldbury, Baddesley Ensor and Warton. The practice has its own pharmacy and is a dispensing practice. The practice has five male GPs and two female GPs, a practice manager and deputy practice manager, nursing and dispensing staff, administrative and reception staff. There were 15032 patients registered with the practice at the time of the inspection.

The practice is open from 8.30am to 6pm Mondays, Tuesdays, Wednesdays and Fridays and from 8.30am to 6pm on Thursday. Home visits are available for patients who are too ill to attend the practice for appointments. Open surgeries are held Monday and Friday mornings from 8.45am till 10.30am. There is also an automated and on-line booking system which allows patients to make, check or cancel appointments 24 hours a day, seven days a week.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics, such as disease management clinics for asthma, diabetes, heart disease and stroke, chest, and occupational health. It offers child immunisations and minor surgery clinics. Practice nurses can be seen by appointment for blood pressure monitoring and new patient checks. The practice has its own on site pharmacy. The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed provided by Care UK, based at George Eliot hospital.

Atherstone Surgery has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

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 was 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.

How we carried out this inspection

Before our inspection of Atherstone Surgery we reviewed a range of information we held about this practice and asked

Detailed findings

other organisations to share what they knew. We contacted North Warwickshire Clinical Commissioning Group (CCG) and NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 10 February 2015. During our inspection we spoke with a range of staff that included three GPs, the practice manager, nursing and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with two patients who visited the practice during the inspection. We reviewed 45 comment cards where patients and members of the public had shared their views and experiences of the practice.

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

- 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time.

Staff told us they were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, we saw where a recent incident had been reported in 2014 regarding an error in medicine prescribing that had been acted upon. We saw that significant events had been discussed at practice meetings which demonstrated the willingness by staff to report and record incidents.

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 year and we were able to review these. Significant events were a standing item on the practice meeting agenda. We saw that minutes of the meetings were circulated to relevant staff by email and staff we spoke with confirmed this.

We saw examples where near misses had been investigated and that the learning from these had been shared with all clinicians. Changes had been put in place to reduce the risk of these recurring. When something went wrong it was the practice's policy to inform any patient affected by this, to apologise and inform them of the actions the practice had taken. GPs we spoke with confirmed this. 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.

National patient safety alerts, medical devices alerts and other patient safety alerts were shared by email to practice staff. We saw for example, that recent guidance had been shared on how staff were to manage Ebola, an infectious disease. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and clinical meetings to ensure everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that any action taken had been recorded appropriately.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training for safeguarding adults and children. We asked members staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw that contact details for relevant agencies were easily accessible to staff.

The practice had a nurse practitioner appointed as the lead for safeguarding vulnerable adults and children. The GPs at the practice had been trained to an appropriate level and those we spoke with demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access the policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. The safeguarding lead was aware of vulnerable children and adults registered with the practice and records demonstrated good liaison with partner agencies such as the health visitors and social services.

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 such as vulnerable patients, or children and young people who were looked after or had child protection plans. GPs appropriately used the required codes on their electronic case management system to ensure risks were clearly flagged and reviewed.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard, in consultation rooms and on the practice's website. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Clinical staff usually acted as chaperones but the practice

manager told us other staff were able to carry out this role when they had completed their chaperone training. We saw records to show that chaperone training had been done and staff we spoke with confirmed they had completed this training.

Medicines management

We saw that the practice had policies and procedures in place for the management of medicines dated July 2014. This included safe stock control, dispensing medicines to patients, disposal and safe storage of vaccines. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. 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 and these were tracked through the practice and kept securely at all times.

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 and this described the action to take in the event of a potential failure. The practice staff confirmed they followed the policy. We saw that fridge audits were carried out regularly, with the last audit completed 31 January 2015. The audit recorded details of the fridge temperatures and stock levels held. The audit had identified that no actions were required.

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 (HCAs) administered vaccines using directions that had been produced in line with both legal requirements and national guidance. We saw up-to-date copies of both sets of directions, such as those for shingles and nasal spray for flu. We saw evidence that nurses and the HCAs had received appropriate training to administer vaccines.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were to be managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We saw that a controlled drugs register was kept and stock levels monitored on a monthly basis. There were arrangements in place for the destruction of controlled drugs when no longer needed.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strengths used. Staff told us they were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. For example, we saw certificates that showed all dispensers held appropriate qualifications in pharmacy services. We saw also that staff carried out annual self-assessments. We saw records dated April 2014 that confirmed this.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We saw from the comment cards that patients always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff had received induction training about infection control specific to their role when they started to work at the practice. We saw evidence to show that regular infection control audits had been carried out, with the latest audit completed recorded as December 2014. Any improvements identified for action had been discussed at team meetings and we saw minutes of meetings that confirmed discussions had taken place. Action plans

developed from these audits were followed up at three monthly intervals to check on progress that had been made. Dates for both audits and action plan follow ups had been planned and were recorded in the practice diary.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. We saw that the infection control policy had been reviewed in December 2014. Disposable equipment and washable screen curtains were used in treatment rooms. We saw that a washing schedule was in place for the curtains, with a record kept in a log book and recorded on the curtains. We saw that personal protective equipment including disposable gloves, aprons and coverings for couches were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

We saw that staff had access to the infection control policy on the practice intranet and posters were displayed in consultation rooms. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines in place informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment rooms to guide staff.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy 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 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 we saw stickers indicating the last testing date were displayed. We saw that a schedule of testing was in place.

We saw records that confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during 2014. Electrical tests and calibration of equipment was next scheduled to be done in March 2015.

Staffing and recruitment

We looked at records that contained evidence to confirm appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, 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. This included the completion of a risk assessment for non completion of DBS checks for non-clinical staff. We spoke with newly recruited staff who confirmed that all the checks had been carried out prior to their employment.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us they worked additional hours to cover sickness and annual leave within the practice.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management,

Good

Are services safe?

staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and were followed up if they failed to attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should one occur. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and records we saw confirmed these were checked regularly. Staff confirmed that any instances where emergencies had occurred would be discussed at the practice's significant event meetings.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw that the practice had carried out a fire risk assessment that included actions required to maintain fire safety. A member of staff was the appointed lead for fire safety at the practice and ensured that all aspects of fire safety were maintained. We saw records that showed staff were up to date with fire training. We saw that fire extinguishers were checked annually and that the last check had been done 21 January 2015. All other checks were carried out routinely and included the fire alarm, lighting and extinguishers.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of an electrical company to contact in the event of failure of the electricity supply, and utility services such as heating and water suppliers. We saw there was a procedure in place to protect computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw copies of the guidance that had been circulated to clinical staff by email. We saw minutes of practice meetings where new guidelines had been discussed and shared

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. We saw that the implications for the practice's performance and patients were discussed and required actions agreed during the practice meetings. 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.

GPs at the practice each led in specialist clinical areas such as diabetes, substance misuse, dermatology (skin), family planning and sexual health. The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff felt able to ask for support or advice if they felt they needed it.

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

Management, monitoring and improving outcomes for people

Staff throughout the practice had key roles in monitoring and improving outcomes for patients. These roles included infection control, scheduling clinical reviews, managing child protection alerts and medicines management.

We spoke with GPs to determine how they decided on which audits to carry out. They 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 national performance measurement tool. Following the audits, the GPs shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice showed us a sample of five clinical audits that had been undertaken in the last five years. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

We saw that these five audits were completed cycles where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw three audit cycles for implant procedures that had been completed every two years in 2010, 2012 and 2014. The audits reviewed the number of activities complete and the outcomes of these. The audits showed that the practice remained consistent in their approach throughout the audit cycles. Another audit had been carried out in 2013 and repeated in 2014 on the prescribing of anti-inflammatory medicines. The results of these audits demonstrated a reduction in prescribing, from 460 prescriptions reduced to 326 on the repeated audit.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance, particularly in relation to post-operative rates of infection.

The practice also used the information collected for the QOF and performance against national screening

Good

Are services effective?

(for example, treatment is effective)

programmes to monitor outcomes for patients. In some areas the practice had reached performance levels that were slightly lower than the national average. For example, 70% of patients with dementia had received an annual medicine review which was lower than the national average of 84%. This was also highlighted in performance data that showed the practice had achieved 93% for their total QOF points compared with a national average of 94%. The practice manager told us they reviewed their QOF performance and took steps to address areas where the data showed they were below the national average.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where 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 undertake at least one audit a year.

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 patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed specific medicines. We saw evidence that confirmed that, after receiving an alert, the GPs reviewed the use of the medicine in question and, where they continued to prescribe this outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment to meet patient's needs.

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff had completed up to date training such as annual basic life support. We noted a good skill mix among the GPs who collectively had additional diplomas in ophthalmology (eyes), occupational health, substance misuse, diabetes and dermatology (skin). Two GPs were also qualified to train medical students from Warwickshire Medical School. 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 (GMC) can the GP continue to practise and remain on the performers list with NHS England).

We saw from records that staff undertook annual appraisals. Through the appraisal system individual learning needs had been identified and action plans had been developed and documented to how those needs would be met. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, staff told us they were able to access on line training courses as well as vocational courses as these became available.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, travel vaccines, ear syringing, stop smoking programme and lifestyle advice. Those nurses with extended roles as in monitoring patients with long-term conditions such as asthma, diabetes and heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. We also saw records and training certificates that showed how clinical staff had maintained their qualifications and skills to carry out their roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. 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.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings were attended by health visitors and palliative care nurses. We saw minutes of meetings that confirmed this. Decisions

Good

Are services effective?

(for example, treatment is effective)

about care planning were documented in the patient's record. Staff told us this system worked well. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared.

We spoke with three managers from care homes and nursing homes whose patients were registered with the practice. They told us a GP visited patients regularly each week at the home. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used (VISION) by all staff to coordinate, document and manage patients' care. All staff were trained to use the system and told us they found it easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used 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. The practice made referrals directly and through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported that this system was easy to use.

Consent to care and treatment

A nurse practitioner at the practice was a specialist in mental health. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

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. We saw data that confirmed regular care plan reviews were carried out.

The practice had not needed to use restraint in the last three years, but staff we spoke with told us they were aware of the distinction between lawful and unlawful restraint and gave an example, such as false imprisonment.

Health promotion and prevention

GPs at the practice worked to individual lists of patients as they considered this service provided better individualised care and promoted close and longer term relationships with patients. Comments from some patients confirmed that they had known their GP for many years and that they preferred to see a GP who knew them and their medical history.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurses. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews, offering lifestyle advice, or to review the patient's long term condition.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice used numerous ways to identify patients who needed additional support, and were pro-active in offering

Good

Are services effective?

(for example, treatment is effective)

additional help. The practice was actively involved in research. GPs told us they were members of the Primary Care Research Network, and this helped them keep up to date with new developments to the benefit of their patients. They gave us two examples where being involved in research had helped with new treatments, such as for psoriasis (a skin condition) and alternative medicines for treating patients who had a depressive illness. The practice was also committed to the national exercise referral scheme where patients were offered access to a local gym at reduced costs for a 12 week course.

The practice also provided medical care for patients who lived in a specialist dementia nursing home and two care homes locally. They provided a weekly ward round at the nursing home and visited patients in the care homes as was needed. These visits were carried out by a named GP to ensure continuity of care was maintained. This was confirmed by the managers of the homes we spoke with.

The practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. The practice also had close links with the community learning disability team. Similar mechanisms were in place to identify patients at risk such as those who were likely to be admitted to hospital and or patients receiving end of life care. These patient groups were offered further support in line with their needs. The practice offered health checks to patients over the age of 75 which included frailty checks. Memory and mobility assessments were also included in these checks.

Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams to ensure that all professional staff had access to accurate patient information.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend by either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease. For example, last year's performance for patients with diabetes who had received the flu vaccine at 99% was higher than the national average of 93%.

Last year's performance for cervical smear uptake was 88%, which was slightly higher than the national average of 82%. There was a policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend. There was a named nurse responsible for following up patients who did not attend screening.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the carer support service, victim support.

We saw that the practice had access to a database of support organisations that they were able to signpost patients to for further information. The practice was also designated as a Place of Safety for vulnerable people and staff had been trained accordingly. A place of safety is a community place where people could go to get help if they felt unsafe, at risk or vulnerable when they were out in the community.

We saw that a range of leaflets were available in the waiting rooms and included leaflets for the Health and Care Professions Council so that patients could check that professional staff were suitably qualified for the work they carried out should they wish to do so.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

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 GP Patient Survey dated July 2014 and a survey of patients undertaken by the practice in 2014. The evidence from these sources showed that patients were satisfied and felt they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 76% were satisfied with appointment times which was comparable with the national average of 77%; 81% described their experience of making an appointment as good compared with a national average of 76%; and 82% would recommend this practice to someone new to the area which compared with a national average of 78%.

Patients were invited to complete CQC comment cards to provide us with feedback on the practice. We received 45 completed cards from patients and all but five gave positive feedback about the service they experienced. Patients commented that they felt the practice offered an excellent supportive service. They said that staff were helpful, friendly and they were happy with the service they received. They noted that staff treated them courteously, with respect and they wouldn't like to go anywhere else for their healthcare. Five patients indicated that they had found their experiences at the practice generally positive but also made some comments that were less positive. These related to the pharmacy, and appointment access. The comments were however, individual and did not identify any themes or trends.

We spoke with two patients during the inspection and both confirmed they were treated well by the practice. They told us that staff were respectful and always willing to help where they could, in a friendly and compassionate way.

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

Staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw information displayed in the reception area that confirmed this.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

The practice operated an individual patient list with a named GP. GPs told us they were able to develop relationships with patients through this approach. They told us this knowledge and relationship with their patients supported the care they were able to provide and thereby reduce and prevent hospital admission.

Care planning and involvement in decisions about care and treatment

Patients told us on the comment cards that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also commented that they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the 2014 national patient survey showed 86% of practice respondents said the GPs were good at involving them in decisions about their care which was slightly higher than the national average of 82%. The proportion of patients who stated that they always or almost always saw or spoke with the GP they preferred was 60% compared with the national average of 38%.

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that patients were always encouraged to be involved in the decision making process. They told us that they would

Good

Are services caring?

always speak with the patient and ask them for their agreement before any treatment or intervention was given, even if a patient attended with a carer or relative. The nurses told us that they would refer any patient to a GP if they thought a patient was unable to understand or lacked capacity, so their care needs could be reviewed.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals.

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

Patient/carer support to cope emotionally with care and treatment

Comment cards completed by patients were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required. Patients commented that the staff had always been there for them and their family, and that they were always supportive regardless of how large or small the issue may be.

Notices and leaflets in the patient waiting room and on the practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw that regular multi-agency meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives or carers in the waiting room and on the practice website. This included information to advise patients what to do if a death occurred at home or in hospital. Staff told us families who had suffered bereavement were called by their usual GP. This call was followed by a patient consultation at a flexible time and location to meet the family's needs and or by signposting to a support service.

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 people'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. The practice population was comparable to the national average for GP practices. For example, national patient data showed that the practice population for the unemployed population group was 5% compared with the national average of 6%; 20% of the practice population were aged 65 years or over compared with the national average of 17%; and the practice working population group was 57% compared with the national average of 60%. The data showed however, that the patients who experienced deprivation was 19% compared with the national average of 24%. For the remainder of the population groups the practice population compared with or was slightly lower than the national average.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they used these sessions to give dietary advice and support for patients on how to manage their conditions. The practice used the Choose and Book referral system. The Choose and Book system enabled patients to choose which hospital they preferred and book their own outpatient appointments in discussion with their chosen hospital.

Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

A range of clinics were held to meet the needs of the various population groups and situations. For example, for families, children and young people there were clinics for child health and immunisation, minor surgery, antenatal care provided alongside the community midwife, and family planning. For people with long term conditions regular clinics were held for monitoring patients' blood pressure, asthma, diabetes, epilepsy and hyperthyroidism. For working age patients the practice offered a full range of screening and health promotion clinics such as heart disease prevention.

The practice told us they had seen an increase in their register of patients who experienced poor mental health including dementia. In 2009/10 the diagnosis rate had been 28%. The current rate had been identified as 57% within their patient population. The practice worked closely with multidisciplinary teams to provide support for patients. This included the mental health team who provide a service for patients at the practice each week. The practice planned to take part in a scheme run by the Alzheimer's Society to develop dementia friendly communities by training people to become dementia friends. Staff training was planned to focus on dementia at the next protected learning time.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This group was made up of a group of patient volunteers and members of the GP practice team. The purpose of the PPG was to discuss the services offered and how improvements could be made to benefit the practice and its patients. For example, the latest PPG action plan had requested that patients were supported by staff to use the automated check in system when they arrived for their appointments. From survey results the PPG saw that the majority of patients had not used this system. Patients were to be encouraged by staff and PPG members and made aware of the benefits of using the system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, we saw that services were provided for the local Polish community, patients with a learning disability, patients who were unemployed and carers of patients.

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us they would arrange for an interpreter if required and that information could also be translated via

Good

Are services responsive to people's needs?

(for example, to feedback?)

the internet. A female GP worked at the practice and was able to support patients who preferred to see a female GP. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice was on one level and there were no steps to make access difficult. Doors were wide enough for patients in wheelchairs to gain access. There was a toilet which was accessible to patients with mobility difficulties.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice had access to online and telephone translation services and a nurse who was able to use sign language which was helpful for those patients and carers who communicated in this way.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message which gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service provided by Care UK, based at George Eliot hospital was available to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice building was open from 8.30am to 6pm Mondays, Tuesdays, Wednesdays and Fridays and from 8.30am to 6pm on Thursdays. Home visits were available for patients who were too ill to attend the practice for appointments. Open access surgeries were held Monday and Friday mornings from 8.45am till 10.30am. There was also an automated booking system which allowed patients to make, check or cancel appointments 24 hours a day, seven days a week. Home visits were made to local care and nursing homes on a specific day each week, by a named GP. The practice was closed at weekends.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. We tracked four complaints and found these had been handled satisfactorily, in a timely way with learning identified where appropriate.

We saw that four complaints had been logged for the previous 12 months, although records of complaints received had been kept for many years and were available at the practice. The letters and emails of complaint had been received by the practice, which indicated patients knew how to complain. We saw that both informal and formal complaints had been recorded. All complaints received had been looked at and actioned however serious or otherwise they were. For example, that a patient had made a complaint because they felt they had been treated disrespectfully by staff at the practice. We saw evidence that the practice had responded to the patient's concerns and an apology had been made. The practice had discussed the learning from this during a staff meeting and changes had been made as a result. We saw staff meeting minutes that confirmed this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Accessible information was provided to help patients understand the complaints system on the practice's website and in the practice's leaflet. Patients we spoke with told us they had never needed to make a complaint about the practice. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. They also confirmed they had never needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on. We saw that compliments received by the practice had been kept.

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 sent us a statement of purpose before our inspection which laid out their aims and objectives. The aim of the practice was to provide a professional and high quality service to its patient population. The practice considered they would achieve this aim by offering a high quality of care to patients through their commitment to training and education. The practice intended to achieve this by keeping up to date with the advances in primary care and ensuring staff were encouraged to continue their professional development throughout their career at the practice and explore further avenues of interest where appropriate.

The practice aimed to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. GPs we spoke with confirmed this. We spoke with six members of staff and they all demonstrated that they understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with GPs who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and the practice manager were very supportive.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at eight of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measurement tool. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had completed a number of clinical audit cycles which included audits for medicines prescribed to thin blood and medicines prescribed to prevent the loss of bone mass.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We found that the practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages, building maintenance and security. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks such as needle stick injuries.

Leadership, openness and transparency

There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. We saw that named members of staff had lead roles. For example, there were clinical leads for patients with a learning disability, asthma, lung disease, diabetes, mental health, blood pressure, palliative care and safeguarding. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by everyone at the practice.

Staff told us that there was a positive, open culture and focus on quality at the practice. Staff said they had the opportunity and felt comfortable about raising any issues at team meetings. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. The practice manager told us that they met with

Are services well-led?

Good

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

the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and practice manager were very supportive. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw there was a system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken. One of the GPs at the practice summarised information from the Drug and Therapeutics Bulletin taken from British Medical Journals and shared the information with all clinical staff at the practice by email. Further discussions about the information were discussed at practice meetings.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and that the GP partners were visible and accessible. Staff told us that they enjoyed working at the practice and that everyone worked well together.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, an induction policy and a recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. 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 an active patient participation group (PPG). The purpose of the PPG was to discuss the services offered and how improvements could be made to benefit the practice and its patients. This PPG was made up of a group of patient volunteers and members of the GP practice team. We saw reports from the last two years where the group had met and had discussed a range of topics. This included the results of the patient surveys that had been completed during the years 2013 and 2014.

The results of the survey of patients had identified a number of areas that would help to improve the service provided by the practice. For example, patients had requested that the waiting room was redecorated. We saw that the practice agreed to obtain quotations for this work for further consideration. Patients had identified that there was often a wait for telephones to be answered when they telephoned for appointments. The PPG discussed this and suggested that patients should be encouraged to use the automated check in system when attending for appointments and to make appointments through the online system where possible. The PPG had suggested that promotion of these services to patients would free up reception staff to answer telephones more freely.

Staff told us the practice shared the survey results with the whole team for discussion at their staff meetings. This gave staff the opportunity to give feedback on any of the findings from the survey report. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

We saw from minutes that staff meetings usually took place every month. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed that they knew who to talk with in the event they had any concerns.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event

Are services well-led?

Good

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

reporting had been discussed at the practice meeting held in October 2014 which had related to a complaint we had tracked. We saw that the details of the incident, who was involved and action taken had been discussed.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with staff at practice meetings.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.