The Langton Medical Group

Quality Report

Langton Grange Medical Centre
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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 21 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.
- Risks to patients were assessed and well managed, with the exception of general risk assessments relating to the environment and working practices.
- 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 had good facilities and was well equipped to treat patients and meet their needs.
- 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.

We saw several areas of outstanding practice including:

Summary of findings

- There was a clear understanding among staff about safety and learning from incidents. Concerns, near misses, significant events (SE's) and complaints were appropriately logged, investigated, actioned and reviewed. All staff were actively encouraged to raise issues and attend the meetings where significant events and vulnerable patients were discussed. Staff were confident to raise issues and were fully informed about any learning that needed to take place to prevent incidents happening again.
- The practice had achieved the Quality Practice Award by the Royal College of General Practitioners in 2010. Quality Practice Award is the highest attainable award available from the college encompassing a large clinical component and assessment of patient experience.

The provider should:

- Carry out risk assessments to manage and monitor the risks to patients, staff and visitors.
- Ensure that any discussions relating to changes to National Institute for Health and Care Excellence guidance and implications for the practice are recorded for future reference.
- Seek to identify patients who also have caring responsibilities during consultations.
- Review the access to and availability of appointments, and how the reception desk and telephones are manned.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice had a system in place for reporting, recording and monitoring significant events. All staff were encouraged to forward incidents to be discussed, and all staff attended the practice meetings, where incidents were discussed. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were 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 had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The majority of patients told us they were able to book appointments

Summary of findings

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 was aware of these issues and introduced afternoon surgeries and there were plans to install a new telephone system.

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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were some systems in place to monitor and improve quality and identify risk, although the recording of these needs strengthening. For example not all potential risks had been identified. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. 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 identified those patients most at risk of admission to hospital and developed and agreed care plans with these patients. It was responsive to the needs of older people and offered home visits if required and rapid access appointments for those with enhanced needs. The practice identified if patients were also carers, and information about support groups was available in the waiting room.

People with long term conditions

Good

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 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.

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, for example, children and young people who had a high number of accident and emergency attendances.Any child identified as potentially or at risk was discussed at meetings attended by all practice staff. 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 an integrated eight week check, at which they saw the practice nurse and health visitor, with GP support available if required.

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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 offered extended hours one day a week at the main practice. 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

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Adults identified as being vulnerable were discussed at meetings attended by all practice staff. 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.

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 people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia.

The practice was taking part in a research project looking at cardiovascular risk in patient with mental health needs. The aim of the project is to reduce the cardiovascular disease risk in this group of patients.

Summary of findings

What people who use the service say

We spoke with six 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. All six patients spoken with during the inspection told us about the difficulties making appointments, either via the telephone or in person.

We reviewed the 27 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 the majority of comments were positive. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Four patients made comments that were less positive and these were about the appointment system.

We looked at the national patient survey published in January 2015. The survey found that 87% of respondents stated that they were able to get an appointment last time they tried and 93% said the last appointment they got was convenient. However 51% of respondents said they were able to make an appointment with their preferred GP, which was below the local Clinical Commissioning Group average of 61%, and 58% found it easy to get through on the telephone, which was also below the local CCG average of 73%.

When asked if they would recommend the practice to someone new to the area, 95% of respondents said they would, which was higher than the CCG average of 82%, and 91% of respondents rated their overall experience of the practice as good.

Areas for improvement

Action the service SHOULD take to improve

Carry out risk assessments to manage and monitor the risks to patients, staff and visitors.

Ensure that any discussions around changes to National Institute for Health and Care Excellence guidance and implications for the practice are recorded for future reference.

Seek to identify patients who also have caring responsibilities during consultations.

Review the access to and availability of appointments, and how the reception desk and telephones are manned.

Outstanding practice

There was a clear understanding among staff about safety and learning from incidents. Concerns, near misses, significant events (SE's) and complaints were appropriately logged, investigated, actioned and reviewed. All staff were actively encouraged to raise issues and attend the meetings where significant events and vulnerable patients were discussed. Staff were confident to raise issues and were fully informed about any learning that needed to take place to prevent incidents happening again.

The practice had achieved the Quality Practice Award by the Royal College of General Practitioners in 2010. Quality Practice Award is the highest attainable award available from the college encompassing a large clinical component and assessment of patient experience.

The Langton Medical Group

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 a Practice Manager specialist advisor.

Background to The Langton Medical Group

The Langton Medical Group is located in the city of Lichfield, Staffordshire. The practice provides services to people who live in Lichfield, Wall, the Longdon Villages, Handsacre, Fradley, Whittington and Elford and the areas in between. The Langton Medical Group also has a branch surgery at Whittington.

The practice has five GP partners and four salaried GPs, GP registrars, three advanced nurse practitioners (one of whom is also a partner), three practice nurses and two health care assistants. The practice also has a business manager, a practice and deputy practice manager and reception and administrative staff, including medical secretaries. There are approximately 11800 patients registered with the practice. The main practice is open between 8am and 6.30pm Monday to Friday, with consultations between 8am and 6pm. The main practice also offers extended hours on Tuesdays between 6.30pm and 8pm. The branch surgery is open between 8am and 12.30pm Monday to Friday, with consultations between 8am and 12.15pm. Patients can be seen at either the main practice or the branch practice.

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 treats patients of all ages and provides a range of medical services. This includes a number of clinics for long term condition management including asthma, diabetes and high blood pressure. It offers antenatal care, child immunisations, minor surgery and travel health.

The Langton Medical Group holds a Personal Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community over and above the General Medical Services (GMS) contract.

The practice has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by Staffordshire Doctors Urgent Care.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, Healthwatch and NHS England Area Team.

We carried out an announced visit on 21 April 2015. During our inspection we spoke to a range of staff including GP, registrars, advanced nurse practitioners and a practice nurse, the practice and deputy practice managers, and reception and administration staff, including medical secretaries. We spoke with six patients who used the service about their experiences of the care they received. We reviewed 27 patient comment cards sharing their views and experiences of the practice. We also spoke with external professionals who worked in liaison with the practice. These included the community matron and district nurse and representatives from two local care homes.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. 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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 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 last 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda, which all members of staff attended. There was evidence that the practice had learned from these and that the findings were shared with all 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 gave us examples of issues they had raised for discussion at the meetings.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager, although staff also used verbal and email communication to inform the practice manager of incidents. We saw 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. For example, the secretaries had raised concerns about how the urgent cancer referrals were made to them by the GPs. A new system was introduced to ensure these referrals were actioned with 24 hours. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to clinical staff. We saw that action had been taken following an alert regarding 'domperidone', a medicine used to treat conditions such as heartburn, bloating or relief of stomach discomfort. An audit had been completed and inappropriate prescribing had been reduced by over 60%, with a further audit planned for May 2015. They also told us alerts were discussed at either the clinical forum meeting or practice meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the majority of staff had received relevant role specific training on safeguarding. We asked members of medical and nursing 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. They were able to show us examples of when patients at risk (both children and adults) had been discussed to ensure the appropriate action had been taken. They also told us they if a child did not attend an appointment or were high attendees at accident and emergency they would review the records to identify if any action needed to be taken. Staff were aware of which GP was the safeguarding lead, and told us they could also discuss any concerns with their immediate line manager.

The practice used a variety of information to identify patients who may be vulnerable and at risk. Secretarial staff told us that when they summarised new patient notes they looked for any potential risks and raised these as significant incidents to be discussed at the practice

meeting. Information received from accident and emergency and the local minor injuries unit was reviewed to highlight vulnerable patients, and the Advanced Nurse Practitioners reviewed information received from the out of hours service on a daily basis.

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 patients with learning disabilities. There was a system in place that highlighted patients with caring responsibilities, although the practice recognised they needed to be more proactive in asking patients if they had caring responsibilities. This would enable the practice to involve carers in the care and treatment decisions for the person they cared for.

The care of children on the register was discussed during practice meetings, which all staff attended. This meant that all staff were aware of which patients were at risk and were mindful to this when they visited the practice. 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, who also attended the practice meeting when possible. This supported two way communication regarding potential children at risk. Weekly child health clinics were held at the practice, and provided an opportunity to discuss any concerns regarding children, both before and after the clinic.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

There was a chaperone policy which was visible in the consulting rooms, but not 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). Information about the chaperone service was included on the practice website. Members of the nursing team acted as chaperones. 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 we spoke with told us they were offered a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We found that practice staff followed the policy.

Processes were in place to check medicines were up to date and suitable for use. Records demonstrated that all medicines used in the practice were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines kept in the nurses' room. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. We saw evidence that nurses and health care assistants had received appropriate training to administer vaccines.

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.

The advanced nurse practitioners (ANP) were qualified as independent prescribers. The prescribing patterns of the ANPs and the GPs were audited, in addition to the overall prescribing patterns for the practice. 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.

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 and had systems in place to monitor how these medicines were collected.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by the Clinical Commissioning Group (CCG) prescribing advisor. The prescribing advisor visited the practice and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. There was an agreement in place with the practice so that the prescribing advisor could initiate changes to patient medicines in response to updates. Staff told us about a recent change in the manufacturer of inhalers for asthma. The prescribing advisor wrote to the patients concerned and invited patients to meet with them to discuss the changes. The practice also wrote to the patients to notify them of the changes.

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 practice had a lead for infection control who was responsible for carrying out infection control audits and supporting staff training. Staff told us they received infection control training, and the most recent training had included scenarios, for example management of a blood spillage. We looked at the most recent infection control audits carried in December 2014 / January 2015 at both the main and branch practices. Action plans had been developed for both premises and work was ongoing to meet these actions.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Spillage kits were available to manage any spillage of bodily fluids and mercury spillages.

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. 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. The practice had informally risk assessed whether staff within other teams required protection. Staff told us procedures were in place so that reception staff did not handle specimens brought in by patients. 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 landlord of the building was responsible for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The business manager told us that the landlord had carried out a risk assessment had been carried out, although this was not available at the practice. We saw evidence to support that the risk assessment had been carried out, and preventative measures such as flushing through taps was carried out.

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 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 and spirometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the 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.

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

Good

Are services safe?

place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had 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 risks relating to areas such as the building or safe working practices and recorded these in a risk log. Some information was available to minimise risk, for example control of substances hazardous to health (COSHH) data sheets were available in the cleaners' cupboard, as well as in folders at the main and branch practices and held electronically.

We saw that staff were able to identify and respond to risks to patients including deterioration in their well-being. For example, procedures were in place to deal with patients that experienced a sudden deterioration in health, and for identifying acutely ill children to ensure they were seen urgently. Staff described how they managed the situation when a mother presented at reception with an acutely ill baby.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

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. 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, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The document was stored off site as well as in fire proof boxes in the building. Each evening staff printed off the appointment lists for the following day, so the daily routine could continue even if the computer system was not available.

The practice had carried out a fire risk assessment in January 2014 that included actions required to maintain fire safety. Although the recommended review date was January 2015, there was no evidence to support that a review had been carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs had lead roles for specific medical conditions and were responsible for reviewing guidance relating to their lead role, and implementing changes as required. For example, guidance to change from one type of cholesterol lowering medication to another had been implemented when patients on this medication attended a consultation. Guidelines relating to chronic obstructive pulmonary disease (lung disease) had also been implemented during the previous 12 months with support from the pharmacist. However discussions around changes to NICE guidance and the implications for the practice were not recorded in the minutes of practice meetings to ensure all staff were aware of these and could refer to them when needed.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The senior GP partner showed us data from the local Clinical Commissioning Group of the practice's performance for antibiotic prescribing, and the rate was higher than for similar practices. The practice had put procedures in place to address this and had made all GPs and Advanced Nurse Practitioners aware of the changes. Prescribing rates for other medicines were comparable to similar practices.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The information staff collected was then collated by the deputy practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that been undertaken in the last two years. They were all completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We looked at the audits and they covered a range of areas of practice, for example, safe management of sharps, medication and care plans for care home patients. Following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a specific medicine 'domperidone' used to treat conditions such as heartburn, bloating or relief of stomach discomfort, an audit was carried out. The guidance was that this medication should not be prescribed long term for these conditions without reassessment at a routine appointment to advise on treatment continuation, dose change or cessation. The first audit demonstrated that 81patients were prescribed the medicine. Alerts were placed on the electronic patient note system to remind clinicians to review this medicine with the patient during any consultations. A second audit was completed six months later which demonstrated that 27 patients were currently prescribed the medicine. This correlated to a 66% reduction in prescribing of domperidone.

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 is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 96.2% QOF which was

Good

Are services effective?

(for example, treatment is effective)

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 reviewed these care plans every three months. Systems were in place to ensure the 'call back' facilities were in place for the highest priority patients. The practice also offered enhanced services for minor surgery and insertion of intra uterine devices and contraceptive implants (to prevent pregnancy). An audit of infection rate following minor surgery was carried out in 2013/2014 and demonstrated a low rate of infections.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice was supported by the prescribing advisor from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. There was an agreement in place for the prescribing advisor to amend patients' medicines as required.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses, specialist nurses and took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of 70 patients and alerts within the electronic patient notes making clinical staff aware of their additional needs.

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 among the doctors with two partners having diplomas in child health and other partners having additional qualifications in sexual and reproductive medicine and family planning. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. 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 staff attending training relevant to their role. The nursing staff told us they had regular meetings and had started to hold group reflections in preparation for revalidation for nurses with their professional body. 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.

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, 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. Several GP partners had a lead role for long terms conditions and supported the nursing team 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 hospitals including discharge summaries, out-of-hours GP services and the 111 service electronically, by post and by fax. 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

Good

Are services effective?

(for example, treatment is effective)

were received. The GP or Advanced Nurse Practitioner 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 multidisciplinary team meetings every six weeks to discuss patients with complex problems, for example those with end of life care needs or receiving care from the community nurses, as well as any children of concern. These meetings were attended by the community nurses, palliative care staff and the health visitors. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We spoke with a community matron and district nurse who worked closely with the practice. They told us they a good working relationship with the practice and benefited from being in the same building. They confirmed they attended the multidisciplinary meetings and felt that their contribution was valued.

We spoke with representatives from two local care homes. They told us they had a good working relationship with the practice, and the GPs respected the views and opinions of the staff.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Care plans for the most vulnerable patients and been developed and were kept in their home / care home. The care plans contained a summary of medical conditions, medication, recent blood test results, emergency contact details for carer / next of kin as well as the plan of care. 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 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

Clinical staff had received training on the Mental Capacity Act 2005, Gillick competence and consent as part of their protected learning time. 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. 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. A 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.

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. We spoke with representatives from two local care homes who told us that GPs discussed end of life care and the DNACPR care plans with the patient and their families. One of the representatives from a home for people with learning disabilities described how the practice had supported them to provide end of life care for a terminally ill patient so they were able to remain in their own home. They also told us the named GP who visited the service contributed to best interest decisions through multidisciplinary meetings, if the patient did not have the capacity to give informed consent.

There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained and scanned on to the patient's notes.

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. An assessment of the individual's mental capacity was recorded in the careplan and the template completed in the electronic patient record. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). There were 106 patients on the dementia register and care plans were in place for 82 (77%) of these patients.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

All new patients were required to complete a health questionnaire as part of the registration process. This included information about medical conditions, family history, smoking and alcohol intake. New patients were offered a 'new patient' appointment on registration.

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 the Waistlines for weight management. Waistlines is a free, personalised adult weight management service covering Staffordshire. 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 were displayed on the television screen in the waiting room.

The practice offered sexual health and family planning advice and support. Chlamydia screening was available for patients aged 18 to 25 years, and the testing kits were available for patients to take away.

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 national average.

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 or a mental health condition and these patients were offered an annual physical health check. The practice's performance for cervical smear uptake was 81.3%, which was in line with the national average. There was a policy to send reminders for patients who did not attend for cervical smears.

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 113 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 273 patients undertaken by the practice, report dated March 2015. The practice also received comments 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. 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 91% of patients rated their overall experience of the practice as good. The survey showed that 91% of patients felt that the doctor was good at listening to them, and 95% said the GP gave them enough time. Both of these results were above the local Clinical Commissioning Group (CCG) average.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were very positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 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 / 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. Telephones were answered at the reception desk but staff were careful to ensure they were not overheard. There was a system in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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. One patient commented on their comment card that they were given clear advice and instructions on what would happen next.

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 carried out during January-March 2014 and July-September 2014 showed 89% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 92% of practice respondents said the nurse involved them in care decisions and 91% felt the nurse was good at explaining treatment and results. The results from the survey carried out by the practice were similar.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us that translation services were available for patients who did not have English as a first language.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, those with mental health difficulties or dementia, complex health needs or end of life care. The practice had identified those patients most at risk of admission and individual care plans had been developed and agreed for these patients. The practice worked closely with the integrated community team (community matron, district nurses and social services) and met monthly to discuss patients with complex health needs, end of life care needs and those being case managed by the integrated team. We saw systems were in place to ensure patients

Good

Are services caring?

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 94% 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 told patients how to access a number of support groups and organisations.

Patients were asked on registration if they had any caring responsibilities and the computer system alerted staff if a patient was also a carer. The GPs recognised that they needed to be more proactive about asking patients about caring responsibilities to ensure they identified changing circumstances.

Systems were in place to notify staff if families had suffered a bereavement. There were alerts on the electronic patient notes so staff were aware that the family may need extra support if they contacted the practice. The GPs told us they would contact relatives following a bereavement if they felt it was appropriate. Staff also told us the practice contacted the family on the first anniversary to offer additional support if required. .

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 patients' needs and had systems in place to maintain the level of service provided. For example, the practice offered extended hours each week for patients with work commitments or who were unable attend during routine opening hours, as well as telephone consultations. The practice offered a range of enhanced service, for example minor surgery, coil and contraceptive implant fitting. 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 needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. As part of an enhanced service the practice had identified patients most at risk of unplanned admissions. Care plans had been developed and agreed with these patients and were reviewed every three months.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One of the partners was the lead clinician for elderly care within the CCG. The practice was also part of the Primary Care Research Network based at Keele University. The practice was part of the Primrose Study, looking at the cardiovascular risk in patients with mental health conditions. The aim of the project is to reduce the cardiovascular disease risk in this group of patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback 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. Following comments from the PPG, the practice was looking to install a new telephone system during 2015, which would include a menu to direct patients to the correct department.

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 and staff. They both told us that the GPs carried out regular health checks on the patients, and responded promptly to any requests for home visits.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, seasonal workers, patients with a learning disability and students. 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. Staff told us they had access to translation services if required. We did not see any leaflets in different languages for patients, although information could be translated via the website. There was a mix of male and female GPs at the practice, so patients who preferred to see a female doctor were able to do so. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building, with services for patients on the ground floor. There was a hearing loop system available for patients with a hearing impairment. Staff told us that there were alerts on the electronic system for patients who were sight or hearing impaired. 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 to the building, 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

Practice leaflets and the 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

Good

Are services responsive to people's needs?

(for example, to feedback?)

were convenient to them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone number for the out of hours service was in the practice leaflet and on the website.

The main practice opened from 8am until 6.30pm. The practice offered urgent same day appointments with a GP or Advanced Nurse Practitioner, routine pre-bookable appointments and telephone consultations. Extended opening hours were also provided on Tuesdays between 6.30pm and 8pm at the main practice. These were particularly useful to patients with work commitments.

Patients expressed mixed views regarding the appointments system. The majority of comment cards did not express any concerns about the appointment system. However, four patients made comments about the appointment system. They said it could be difficult to get an appointment. They comments that when ringing at 8am for a same day appointment the telephone lines were busy and often the appointments had all been taken by the time their call was answered. All six patients spoken with during the inspection told us about the difficulties making appointments, either via the telephone or in person. This contrasted with the data from the national GP survey, which found 87% of respondents stated that they were able to get an appointment last time they tried and 93% said the last appointment they got was convenient. However 51% of respondents said they were able to make an appointment with their preferred GP, which was below the local CCG average of 61%, and 58% found it easy to get through on the telephone, which was below the local CCG average of 73%.

The practice partners were aware of the challenges regarding appointments. During the summer of 2014 early afternoon surgeries were introduced at the main practice to increase capacity. The practice had successfully recruited to fill the vacancy created when a GP left in December 2014. The appointment system was discussed at the twice yearly business planning meeting, and an action point was to replace the telephone system during 2015 with a modern system including a menu option for callers.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to nine local care homes on request. The practice also supported patients who lived in an extra care housing scheme, who may also be receiving care in the community.

The practice was able to offer routine appointments outside of school hours for children. Children were offered a same day appointment if requested. Systems were in place to monitor mothers to be, from confirmation of pregnancy through to the eight week post natal check. Family planning services were available and sexual health screening was available.

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 complaints leaflet. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all 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. Learning from complaints was clearly recorded in the complaints log.

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. However, lessons learned from individual complaints had been acted on. For example, information about the role of the practice nurses was now included in the practice leaflet, and choose and book information was posted to patients after two weeks if not collected.

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 of 'learning through caring' and there was a mission statement in place to support this. Both of these were available on the practice website. It was clear when speaking with the GPs and the practice staff that they shared these aims and were committed to providing excellent care that met the needs of the practice population. Several patients commented that they felt listened to and concerns were always taken seriously.

The practice had achieved the Quality Practice Award by the Royal College of General Practitioners in 2010. Quality Practice Award is the highest attainable award available from the college encompassing a large clinical component and assessment of patient experience. It is designed to improve patient care by encouraging and support practitioners to deliver the highest quality care to their patients.

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. However, not all of the policies had been reviewed in line with the dates and consequently contained information that was out of date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and each of the GP partners had lead roles, including safeguarding, long term conditions and end of life care. 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 Primary 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. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing above the national average.

The practice had some arrangements for identifying, recording and managing risks, although these need to be strengthened. For example the practice had not identified risks relating to areas such as the building or safe working practices. The practice did not have a risk log to address a wide range of potential issues.

Leadership, openness and transparency

We saw that a range of staff meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The partners and managers held an extended business meeting twice a year to discuss any issues and carry out forward planning. Informal communication and discussion also took place between the clinicians during the mid morning coffee break.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as the induction policy and equality and diversity 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. 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 practice communicated with the members of the PPG via email. The patient experience survey highlighted issues around telephoning the practice and booking appointments. The results of the survey and action plan were available on the practice website.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). The practice also utilised the patient participation group as a means of two way

Are services well-led?

Good

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

communication to obtain patient views about the service. The practice produced a newsletter in March 2015 to provide patients with information in light of the comments made in the patient survey.