Bridgnorth Medical Practice

Quality Report

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

Ratings

Overall rating for this service	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 31 October 2014 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:

- 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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) 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 planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with a number of 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 to them was easy to understand. 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 and worked to overcome obstacles to achieve this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted upon.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient surveys and from the patient participation group (PPG). A

Summary of findings

PPG is usually made up of a group of patient volunteers and members of the general practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients.

The practice reviewed the needs of its local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Patients told us they could get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. 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 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. The practice promoted quality and safety as its top priority. All practice staff and teams worked together across all roles to achieve high standards. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients through a patient participation group (PPG). A PPG consists of patient volunteers who share their views and respond to surveys through the practice's website. They comment about the services offered and how improvements can 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. For example, we saw that the practice worked in a multi-disciplinary way to provide palliative care for patients. We saw that regular multi-agency meetings were held and recorded.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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 vulnerable patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening 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 patients at risk of harm or patients with a learning disability. The practice had carried out annual health checks and offered longer appointments for patients with learning disabilities.

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

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). People experiencing poor mental health had received an annual physical health check. 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 advanced care planning for patients with dementia.

The practice had advised patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND which supports those with mental health problems. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed 22 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 of these comments were extremely positive. Patients commented that they were impressed with the practice and that they could always see a GP or a nurse 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 of the staff at the practice and that everyone was courteous, happy and polite.

Four patients indicated that although they had found their experiences at the practice generally positive, they had commented on areas which they considered less positive. For example, some commented that they had found difficulty in getting an appointment, or had been unable to see the GP or nurse of their choice when they had wanted to. All four comments were individual and a common theme was not evident.

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 2013. The evidence from these sources showed patients were satisfied with the service they received and that they were treated with compassion, dignity and respect. Data from the national patient survey showed the practice was rated as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 75% were satisfied with appointment times which was less than the national average of 80%; 79% described their experience of making an appointment as good compared with a national average of 77%; and 85% would recommend this practice to someone new to the area which compared with a national average of 79%.

Bridgnorth Medical Practice

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 Manager specialist advisor.

Background to Bridgnorth Medical Practice

Bridgnorth Medical Practice is located in Bridgnorth, Shropshire and provides primary medical services to patients. The practice has seven male and two female GPs, a practice manager, six practice nurses and a nurse prescriber, as well as administrative and reception staff. There were 16,100 patients registered with the practice at the time of the inspection. The practice is open from 8.30am to 8.30pm Monday and Tuesday and from 8.30am to 6.30pm Wednesday to Friday. Home visits are available for patients who are too ill to attend the practice for appointments.

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 which includes asthma, diabetes, heart disease and stroke, chest, and mental illness. It offers child immunisations, family planning, minor surgery, smoking cessation and well person clinics. Practice nurses can be seen by appointment for blood tests, blood pressure monitoring and new patient checks. 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.

Bridgnorth Medical Practice is an approved GP training practice. Fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP.

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.

This provider had not been inspected before and that was why we included them.

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 Bridgnorth Medical Practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Shropshire Clinical Commissioning Group (CCG) and the NHS England local area team (LAT) to consider any information they held about the practice. We spoke with

Detailed findings

the managers of two residential homes where patients lived who were registered with 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 31 October 2014. 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 reviewed 22 comment cards where patients and members of the public 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. GPs told us they held pre-meetings prior to the practice meetings to determine specific agendas. For example, learning outcomes were discussed in educational meetings. We saw that minutes of the meetings were circulated to relevant staff by email, and staff we spoke with confirmed this. We found that reviews of actions from past significant events had not been carried out to enable any recurring themes to be identified.

We saw examples where near misses had been investigated and the learning from these had been shared with all clinicians. Changes had been put in place to reduce the risk of this recurring. 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. 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 disseminated by email to practice staff. We saw for example, recent guidance had been shared on how staff were to manage an infectious disease. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and business 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 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 of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for relevant agencies were easily accessible to staff.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to an appropriate level and 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 policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event that they became concerned that a patient may be at risk of harm. The lead safeguarding GP was aware of vulnerable children and adults registered with the practice and records demonstrated good liaison with partner agencies such as the police 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 who may be subject to child protection plans. GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Good

Are services safe?

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. Nurses and receptionists carried out chaperone duties. We saw that chaperone training had been done and staff we spoke with confirmed they had done this.

Medicines management

We saw that the practice had policies and procedures in place for the management of medicines dated September 2014. This included safe stock control, dispensing medicines to patients, disposal and safe storage of vaccines. Staff told us that 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 as 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, which described the action to take in the event of a potential failure. The practice staff confirmed they followed the policy.

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

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were 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. There were arrangements in place for the destruction of controlled drugs.

The practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff confirmed they were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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

A member of the nursing staff was qualified as an independent prescriber, a nurse who is specially trained to prescribe any licensed and unlicensed drugs within their clinical competence. We saw evidence that showed they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients commented that they always found the practice clean and had no concerns about cleanliness or infection control. 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. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out three clinical audits for 2014 with another audit planned for December 2014. Results of these audits showed that the practice had maintained a high score average of 92%. Any improvements identified for action were emailed to all staff and discussed at team meetings. Minutes of practice meetings showed that the findings of audits had been discussed.

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 for couches were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

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 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. For example we saw that a legionella check had been carried out on 17 September 2014.

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, nebulisers and blood pressure monitoring machines had been carried out during 2014.

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. 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. We were told that locum GPs were used by the practice. We saw that there was a service level agreement (SLA) in place for when locum GPs had been used. A **service level agreement** is a document which defines the relationship between the service provider and the recipient.

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, 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

Good

Are services safe?

of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they failed to attend.

We saw that the practice had identified 330 patients with long term conditions who were at high risk of an unplanned hospital admission. The practice completed care plans with patients and ensured these were followed up and reviewed every three months. The care coordinator managed these patients and called them when their review was due. Patients were given the option to see a GP as part of this review if they felt it was necessary. Care plans were also discussed in monthly multi-disciplinary team (MDT) meetings with health visitors and district nurses.

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.

We saw risk assessments had been completed for risks associated with spillages, contamination and disposal. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We saw that weekly fire testing had been done, with the most recent check recorded as 30 October 2014. We saw that fire extinguishers were checked annually and that the last check had been done 21 January 2014.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of the 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 minutes of practice meetings where new guidelines had been discussed and shared. We saw copies of the guidance that had been circulated to clinical staff by email.

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

GPs told us they each led in specialist clinical areas such as diabetes, lung disease, dementia, heart disease, mental health and thyroid disorders. 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.

GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The 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 five clinical audits that had been undertaken in the last two years. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw that audits dated January 2013, June 2013 and April 2014 had been completed to inform and provide data to demonstrate the evolving practice action plan for patients with long term conditions.

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 programmes to monitor outcomes for patients. For example, 91% of patients with diabetes had received an annual medicine review which was significantly higher than the national average of 78%. In some areas the practice had reached performance levels that were slightly lower than the national average. This was highlighted in performance data that showed the practice had achieved 92% for their total QOF points compared with a national average of 96%. The practice had carried out an audit to identify these areas and had put measures in place. These included the appointment of specific leads to focus and monitor QOF performance areas.

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

Good

Are services effective?

(for example, treatment is effective)

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 to confirm that, after receiving an alert, the GPs had 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 for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

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 training such as annual basic life support. We noted a good skill mix among the doctors who collectively had additional diplomas in maternity, medical education trainer, paediatrics, therapeutics, diabetes, care of the elderly and geriatric care. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans had been documented. 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. 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 or duty GP throughout the day for support.

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, quit smoking programme and lifestyle advice. Those 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.

Working with colleagues and other services

The practice worked with other service providers to meet people's 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 multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by health visitors and palliative care nurses. Decisions 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 the manager from a care home whose patients were registered with the practice. They told us a GP visited patients registered with the practice 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 by all staff to coordinate, document and

Good

Are services effective?

(for example, treatment is effective)

manage patients' care. All staff were trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented them in their practice. Staff described how they would respond if a patient attended with a carer or relative. They told us they would always speak with the patient and obtain their agreement for any treatment or intervention, and if they thought a patient lacked capacity, they would ask their GP to review them. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. 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 examples of records that confirmed care plans were in place and that reviews had been carried out.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw copies of completed consent forms which confirmed the consent process for minor surgery had been followed. We spoke with clinical staff that assisted during minor surgery. They described the procedures they followed and these included obtaining consent during the initial consultation with the patient. This was then reviewed when the patient attended for their minor surgery.

Health promotion and prevention

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 additional help. The practice had engaged in a pilot scheme with the Clinical Commissioning Group (CCG) in which carers worked with patients to identify their support needs and signposted them to other agencies. Relevant patients were signposted to the care coordinator for the programme in various ways. For example, by GPs, by reception staff, by an external agency such as the alcohol advisory service, or patients could self-refer. We were told that this programme had grown in success. We saw evaluations that had been carried out that showed patients and the practice considered the care coordinators as a valuable service. Patients had become more aware of this service through posters displayed which advertised the service.

The practice also kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. 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.

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. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

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

Good

Are services effective?

(for example, treatment is effective)

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 98.6% was higher than the national average of 93.5%.

Last year's performance for cervical smear uptake was 80%, which was slightly lower than the national average of 81%. 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 bereavement service Cruse. 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 had a blood pressure monitoring pod in the waiting area to enable patients to check their blood pressure and monitor their own health. The practice had a policy in place for the receptionists to refer patients who used this pod to a GP if their results reached a specific level.

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 2013. 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 as good or very good by 84% of those patients who responded. The practice was also above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 75% were satisfied with appointment times which was less than a national average of 80%; 79% described their experience of making an appointment as good compared with a national average of 77%; and 85% would recommend this practice to someone new to the area which compared with a national average of 79%.

Patients were invited to complete CQC comment cards to provide us with feedback on the practice. We received 22 completed cards from patients and all gave positive feedback about the service they experienced. Patients commented that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They noted that staff treated them well, politely and with respect. Four patients indicated that although they had found their experiences at the practice generally positive they had commented on areas which they considered less positive. For example, some commented that they had found difficulty in getting an appointment, or had not been able to see the GP or nurse of their choice when they had wanted to. All four comments were individual and a common theme had not been evident.

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

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 leaflets in the reception area and information on the practice website 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.

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 national patient survey 2014 showed 84% of practice respondents said the GPs were good at involving them in decisions about their care which compared with 81% for the national average. The national patient survey showed 87% of practice respondents said the nurses were good at involving them in decisions about their care which compared with 85% for the national average.

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 always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and

Good

Are services caring?

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 and on the practice website 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 very friendly and caring.

Notices in the patient waiting room and on the practice website also signposted people to a number of support groups and organisations. For example, the practice website promoted Silverline, a 24 hour national telephone helpline for older people. The service was free and provided three functions to support older people: a sign-posting service to link them into the varied services that existed around the country; a befriending service to combat loneliness and a means of empowering those who may be suffering abuse and neglect. If appropriate Silverline would transfer callers to specialist services to protect them from harm.

The computer system used by the practice 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 rooms 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 either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service. The practice had also employed their own counsellor and patients were referred for appointments as required. This included patients who required support with mental health concerns including acute anxieties, depression and dementia.

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. Staff told us the practice population consisted of mainly older, retired people. For example, national patient data showed that the practice population for the 65 and over age group was 24% compared with the national average of 16%; and the practice population of 75 years and over was 10% compared with the national average of 7%. For the remainder of the population groups the practice population compared with or was slightly lower than the national average.

The NHS Local Area Team (LAT) 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 carried out regular and routine blood tests for patients with diabetes. They explained they also 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. Patients were also given appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits.

A range of clinics were held to meet the needs of the various population groups and situations. For example, minor illness clinics were held each day to manage increased demand for appointments. These clinics were run by nurses to treat patients with minor illnesses where a face to face appointment with a GP had not been needed. Nurses had support available to them from the on call GP if required. Respiratory clinics were held in late evenings and these were managed by appropriately trained nursing staff. Nurses carried out medicine reviews as part of these clinics. We saw that suitable policies and protocols were in place. Staff confirmed that regular meetings with the lead GP took place to discuss these clinics and the patients who attended. Sexual health clinics for chlamydia screening were held and provided patients with free testing kits and health promotion leaflets were made available. GPs attended local schools to talk with sixth form students about their health and lifestyle options.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. For example, the PPG action plan had requested that a link to support groups such as Arthritis UK was added to the practice website so that patients could access these more easily. We saw that the practice had responded to this feedback and the link had been provided on the website.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. The practice website made information available in many different languages that patients could access easily. Staff we spoke with told us they would arrange for an interpreter if required and that information could also be translated via the internet. Two female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system

Good

Are services responsive to people's needs?

(for example, to feedback?)

available for patients with a hearing impairment and clear signage informing patients where to go. There was a disabled toilet and wheelchair access to the practice for 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 who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. 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. Clinical 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 discussed at staff team meetings. We saw training records that confirmed this training had been completed.

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 giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8.30am to 8.30pm Monday and Tuesday and from 8.30am to 6.30pm Wednesday to Friday. The practice was closed at weekends. Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP.

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 37 complaints had been logged for the previous 12 months. 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, we saw where a complaint had been made by a patient who was unhappy with the way test results had been handled by the practice. We saw evidence that the practice had responded to the patient's concerns and an apology had been made. As a result of this complaint the practice had made changes to the way in which test results were communicated with patients.

Accessible information was provided to help patients understand the complaints system on the practice's website and in the practice's leaflet. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever 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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 vision of the practice was to provide a professional and high quality service to its patient population. The practice considered that to be able to deliver this service they needed to be knowledgeable, caring, competent and compassionate at all times. 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 spoken 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 seven 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. The QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. 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 audits 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. 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.

Following a period of significant change within the practice the GPs told us they were looking forward to the new team becoming established and settled. Significant staff changes at the practice had occurred throughout 2012/2103. For example, four nursing staff had left, retired or taken maternity leave; five GPs left or retired during this time. All staff had since been replaced and a new practice manager and GP partner had been appointed in 2014. A further new partner had been appointed to commence in January 2015. The staff were organised into medical, nursing and reception teams. They operated as separate teams linked by managerial input.

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

Are services well-led?

Good

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

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 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 the 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.

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). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. At the time of the inspection the group had met four times, in which they had discussed a range of topics. This included the results of the patient surveys that had been completed during a period from 2013 and 2014. The practice had participated in two patient surveys. For example, one had been completed by an external company who specialised in patient feedback for the practice, while the other was a survey to find out what patients with arthritis felt about their condition and the support options that were available to them.

The results of the survey of patients with arthritis showed that patients had identified a number of areas that would help them with their conditions. These included exercise facilities, access to classes and access to specific support organisations. The PPG action plan showed that the PPG were to investigate a walking group, yoga and other exercise class options locally; and that a link to arthritis support groups was to be added to the practice website. We saw information had been made available on the practice website. For example, a walking group referred to as the Severn Strollers advertised free walking groups for patients. A variety of walking options were offered to suit patients with different abilities and walking distances.

Patient survey results confirmed the areas the practice had already identified where action and improvements had been needed. For example, the practice was focussed to continue to improve telephone and face to face access to the practice and clinicians. We saw the published survey report that described the adjustments that had been made to both non-clinical and clinician rotas over the previous months which were to be continued during 2014. Further changes were planned to increase staffing levels, increase the use of online appointment booking and online repeat prescription ordering through the practice's clinical system.

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.

Are services well-led?

Good

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

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 through discussion with the GPs and via documentation 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 reporting had been discussed at the practice meeting held in October 2014. 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.