The Aldergate 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 carried out an announced comprehensive inspection at The Aldergate Medical Practice on 2 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services to the population groups of 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 and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Risks to patients were assessed and well managed.
- Some patients told us that it was difficult to make pre-bookable appointments, although all said that they could be seen urgently when required.
- 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.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

Audit the outcomes of patients who receive minor surgery at the practice to help to ensure that surgery undertaken is effective and complications are known, managed and minimised.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. A GP coordinated the practice response to incidents that may affect safety. We saw that 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. We spoke with patients who told us they had been well cared for when they had experienced a health emergency. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and staff had personal development plans in place. We saw evidence of multidisciplinary working. Communications from health partners were handled and acted upon quickly. The practice evidenced they were improving outcomes for patient groups by following best practice guidelines.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

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. Some patients said that it was difficult to make future appointments, although all said they could get an urgent appointment if they needed one. The practice had good facilities and was well equipped

Summary of findings

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. Learning from complaints with staff and other stakeholders.

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 systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 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. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had implemented a system of introducing an advanced nurse practitioner (ANP) as the coordinator for patients in this group. The ANP offered home visits to assess patients in an environment that they may feel more comfortable and GPs offered longer appointments for people with a learning disability. The practice was aware of the need to improve the annual health check results and was looking at ways of doing this.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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). Eighty-seven per cent of 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 advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection. The majority described practice staff as caring, helpful and compassionate. Two patients commented that although they thought the receptionists and GPs were caring, they felt some could be rude occasionally. All of the patients we spoke with said they had confidence in their care and that they were treated with dignity.

We collected 19 cards from a comments box left in the practice waiting room for two weeks before our visit. The comments we received aligned with the comments from the patients we spoke with.

We reviewed the results from the latest GP national patient survey published in January 2015. This survey was based on a return rate of 118 surveys from 275 that were sent out at random to patients registered at the practice. The results showed that 95% of patients felt the GP they last saw was good at listening to them, this was higher than the clinical commissioning group average (CCG) of 90%. We also saw that 100% of patients had confidence and trust in the last GP they saw, this was higher than the CCG average of 97%.

The results of the GP national patient survey in relation to access to the practice by telephone and general experience of making an appointment were below the CCG average. For example 46% of patients found it easy to get through to the practice by telephone (CCG average 73%). Also 59% of patients describe their experience of making an appointment as good (CCG average 75%).

The comments from the comments cards and patients we spoke with about the experience of contacting the practice and making an appointment were mixed. Three out of the 13 patients we spoke with said that it was easy to make an appointment. The remaining 10 patients told us that it could sometimes be difficult to get through on the telephone and make an appointment. The majority of patients told us that the system for making appointments had improved recently and all said that they could be seen urgently if required.

Areas for improvement

Action the service SHOULD take to improve

Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

Audit the outcomes of patients who receive minor surgery at the practice to help to ensure that surgery undertaken is effective and complications are known, managed and minimised.

The Aldergate Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a second CQC inspector, a GP specialist advisor, practice manager specialist advisor and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to The Aldergate Medical Practice

The Aldergate Medical Practice is situated in Tamworth, Staffordshire.

The historic roots of the practice date back 150 years, with the practice occupying the current site since 1990. The building is purpose built and occupies two floors, the majority of treatment areas are on the ground floor. The building has car parking, with allocated spaces for those with a disability. Access to the practice is via a ramp and automatic opening doors, with access to the first floor via stairs or a lift.

There are just over 13,200 patients of all ages registered and cared for at the practice.

The practice team consists of three female and five male GPs, three advanced nurse practitioners (ANPs), a nurse manger, three practice nurses, two healthcare assistants and two phlebotomists. The administrative team take care of the day to day running of the practice and consist of a practice manager, finance officer, two reception supervisors and 12 reception/secretarial team members.

The practice holds a Personal Medical Services contract with NHS England and has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included minor surgery, insertion of contraceptive devices, phlebotomy (taking of blood samples) and the conversion of patients with diabetes who took oral medication to insulin.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by Staffordshire Doctors Urgent Care Limited.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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 visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We spoke with a member of the patient participation group (PPG), we did this to understand the relationship between practice staff and the PPG. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

We carried out an announced inspection on 2 March 2015. During our inspection we spoke with a range of staff including six GPs, a trainee GP, three advanced nurse practitioners (ANPs), a practice nurse manager, two practice nurses, two healthcare assistants the practice manager, two senior receptionists, one receptionist and three members of reception and clerical staff. We also spoke with 13 patients who used the service. We observed how people were cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 19 comment cards where patients and members of the public shared their views and experiences of the service.

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. A GP told us that the practice had discussed significant events for at least the last 10 years. 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

Significant events were raised by completion of a standard form available on practice computers which was completed and submitted to the practice manager. The practice had recorded 20 significant events in the last 12 months. We tracked four incidents and saw that investigation, discussion and action had taken place in a comprehensive and timely manner in all of them. We saw that action had been taken as a result of significant event reporting. For example, a prescription item of medicine for a patient that had previously been stopped by a GP had been restarted on the patients' prescription. This event was investigated and discussed at a monthly clinical meeting. The incident had occurred during the manual transcription of patient records from a legacy practice computer system to a new system. The incident was thought most likely to be a human error. The practice identified the area of risk and introduced a system of individual issue computer smart cards which only allowed key members of staff the computer privileges to alter records.

National patient safety alerts were passed on to staff at the practice clinical meeting by the GP who received them. Staff we spoke with were able to give examples of recent alerts. They also confirmed alerts were discussed at clinical meetings 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 children, young people and vulnerable adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. 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 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. We saw that contact details for local safeguarding teams were easily accessible.

The practice had a dedicated GP as the lead contact in safeguarding vulnerable adults and children. All GPs and nursing staff had received safeguarding training to an appropriate level. All other staff were trained in safeguarding awareness. We reviewed the training of all staff and saw they had training appropriate to their role. All staff we spoke with were aware of who the nominated safeguarding leads were and how to raise a safeguarding concern.

There was a system in place that highlighted vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans.

Children who were registered at the practice and classed as at increased risk of harm were discussed at a monthly meeting with the health visitor to share information and any changes in circumstances were discussed, noted and acted upon. A GP told us that this meeting was a useful way of ensuring that children were reviewed on a regular basis. They also told us that although regular meetings were held any urgent issue would be dealt with immediately if required. We reviewed minutes of the meetings and saw a comprehensive exchange of information had regularly taken place.

The staff we spoke with could clearly demonstrate the action they would take if they had concerns in relation to a patient who did not attend an appointment. For example, if a child did not attend for immunisations. We saw records that showed the practice had followed up patients in this group regularly.

Good

Are services safe?

The practice had a chaperone policy. A chaperone is an impartial, trained observer who is usually a health professional to safeguard the interaction between both patient and clinician during consultations. The policy and signage stating the availability of chaperones was visible on the waiting room notice board, consulting rooms and detailed on the practice website. All nursing staff acted as a chaperone when required. The practice had planned to introduce chaperone training and the relevant character checks required to a number of administrative staff. The practice manager told us this was in response to a risk assessment to ensure that the practice had enough members of staff available at times for unplanned high activity, for example during a medical emergency.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

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.

A GP told us that a pharmacist from the clinical commissioning group (CCG) visited the practice on a bi-weekly basis to provide analysis on the prescribing patterns in the practice. They commented this provided useful feedback on prescribing patterns. A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We reviewed national prescribing data that showed the practice was in line with the national levels of prescribing for antibiotics and medicines known to be addictive such as hypnotics.

The practice nursing team included seven qualified nurses. Two of the nurses were qualified as independent prescribers. They told us they received regular supervision and support in their roles and well as updates in the specific clinical areas of practise that prescribing took place. Five nurses administered vaccines using signed patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

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

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

Cleanliness and infection control

We observed the premises to appear visibly 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 had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control and had received updates specific to their role.

We reviewed records of the most recent practice audit which had been performed in November 2014. The practice had made changes to their working practise as a result of the audit. An example was informing staff that sharps bins used to safely dispose of needles and scalpel blades should be labelled and sealed when being stored awaiting transport to incineration to comply with legislative requirements..

Good

Are services safe?

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

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example, we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice did not have a formal written policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in building). This had been raised in the infection control audit in November 2014. The practice manager told us that the practice had not performed the risk assessment as yet.

Equipment

Staff we spoke with told us they had suitable 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 date of the last test. We saw evidence of calibration of clinical equipment. One example was an electronic blood pressure measuring device.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS). The DBS checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice manager told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on providing minimum numbers of staff to perform reception and call answering duties. In periods of high activity or staff illness, other members of staff were trained and experienced in how to provide reception and telephone duties. The practice manager told us this helped to maintain the day to day staffing requirements and provided additional support in times of high demand on services.

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. We looked at records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

An example was the practice had recently purchased new wheelchairs to assist patients and visitors with poor mobility. The practice manager told us that this had been as a result of a recent risk assessment that revealed the previous wheelchairs had been in a poor condition.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen and nebulisation equipment (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There were a number of

Good

Are services safe?

pulse oximeters available (to measure the level of oxygen in a patient's bloodstream). All the staff knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and available to treat a wide range of medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient experienced a seizure/fit) and hypoglycaemia (low blood sugar level). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had a range of age appropriate emergency medicines available. These included medicines to treat pain, fever and allergic medicines in a liquid form to enable them to be taken by young children. We also saw that the emergency medicine to treat a life threatening allergic reaction in a child was in a pre-loaded syringe and needle device, this could shorten the time taken to administer this medicine in an emergency.

The staff we spoke with were able to tell us how they would deal with patients or visitors who became seriously ill whilst at the practice. Two of the patients we spoke with told us they had received prompt treatment at the practice when they had a serious health concern identified by the GP or nurse who treated them. Both patients told us their circumstances had resulted in an emergency referral to hospital including transport by emergency ambulance. Practice staff had provided information and reassurance to both patients whilst receiving emergency treatment.

The practice had a disaster recovery plan in plan to deal with unplanned events that may occur and hinder operation of the practice. Each risk had been rated and mitigating actions recorded to reduce and manage the risk. The plan included details of alternative accommodation to operate the practice from in the event of a major issue with the existing premises. The document also contained details of who to contact in the event of specific issues, for example contact details for failure of the heating system.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received training in fire safety and fire drills were practised.

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. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We saw that NICE guidelines were available to all clinicians on the practice computers. A GP showed us records of how a patient's treatment for hypertension (high blood pressure) mirrored the latest guidelines. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and 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, poor mental health and family planning. The advanced nurse practitioners (ANPs) and practice nurses supported this work which allowed the practice to focus on specific conditions. An advanced nurse practitioner is a nurse who has undergone further training; they work independently but in close collaboration with a GP. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice provided an enhanced service to identify and support 2% of registered patients at risk of an unplanned admission to hospital. This amounted to 249 patients. All of the patients on the register received a personalised care plan that was reviewed on a regular basis to ensure it met their personal and clinical needs. All of the patients on the register who had been admitted to hospital were contacted on discharge to review their care needs. An ANP told us that the initial contact was by telephone then following discussion an appointment or home visit could be arranged dependent on the needs identified.

The practice had recently introduced a set of aims and objectives to enhance the care it provided for patients who lived in care homes. One of the ANPs led and coordinated the care provided to patients in this group, many of which were in the older age group. The objectives were to be measured by an increase in annual review rates, medication reviews and to reduce accident and emergency and out-of-hours contacts for patients. The practice manager told us that the role provided continuity for patients and care staff and that relatives and patients had requested the ANP to meet with them to discuss care needs. They also commented that the role was planned to promote advance care planning for patients who may be at risk for developing diminished mental capacity, for example patients with dementia. Mental capacity is the ability to make and communicate a decision on given information at that time.

We saw practice records that showed 2819 (21%) of patients were prescribed four or more medications. Eight-three per cent of patients in this group had received a structured annual medication review, which included blood tests to screen for side effects associated with the medicines taken if this was appropriate.

A GP told us that the practice provided cognition testing for patients at risk of developing or displaying symptoms of dementia. Eight patients had been referred to a hospital specialist for diagnosis following cognition testing within the previous 11 months.

The practice kept registers of patients who had long-term conditions including diabetes, cancer, hypertension (high blood pressure) and rheumatoid arthritis.

The practice had signed up to a high number of enhanced services available to practices from the clinical commission group (CCG), NHS England Area Team and Public Health England. A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. An enhanced service is a service that is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included minor surgery, insertion of contraceptive devices, phlebotomy (taking of blood samples) and the conversion of patients with diabetes who took oral medication to insulin. In the previous year the practice had signed up to a total of 36 enhanced services/local enhanced services.

We spoke with the ANP and they were able to give us numerous examples of how this method of review had

improved outcomes for patients. An example was the review of communications surrounding patients who had sustained a fragility fracture. A fragility fracture is a fracture in bone tissue that occurs under forces that would not normally cause a bone to fracture, a major risk factor is in conditions with reduced bone density, such as osteoporosis. The ANP told us that on receipt of the information that a patient had sustained a fragility fracture; they would arrange urgent screening using recognised best practice. The assessment included health risk factors and when indicated a bone density scan would be arranged. We saw that the required assessments and tests were arranged within a short timescale following a patient's discharge. We reviewed data from the quality and outcomes framework (QOF) that showed 100% of patients aged between 50 and 74 who had sustained a fragility fracture and had been diagnosed with osteoporosis were treated with medication to help stop the loss of bone mass. The practice performance in QOF in this area was 18% higher than the CCG average and 14% higher than the national average.

Minor surgery was regularly undertaken at the practice by a number of GPs. The practice did not audit the effectiveness of minor surgery by looking at recognised complications of minor surgery. For example, excessive bleeding or infection rates. A GP told us that they were not aware of any issues and would report any occurrence such as post-operative infection as a significant event. They had been no complaints or significant events raised in relation to minor surgery.

The practice held registers of patients whose circumstances may make them vulnerable. An example was the register for 72 patients with learning disabilities. The care for patients in this group was coordinated by an ANP.

All information about patients received from accident and emergency departments and the out-of-hours service was reviewed by an ANP. A GP told us this provided a clinical evaluation of the information and enabled the practice to assess if the patient would require any further follow up or support.

Patients on the practice register for experiencing poor mental health who attended accident and emergency with a problem related to their mental wellbeing were followed up by their own GP.

We looked at national data from the quality and outcomes framework (QOF). 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 that the practice level for prescribing antibiotics was in line with the national average.

Data from the CCG showed that the practice was in line or had better outcomes with local referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers referred and seen within two weeks. The latest data from NHS England from 2014 showed that 65% of patients with newly diagnosed cancer had been referred under two week referral pathways. This was above the CCG average of 47% and England average of 49%. The two week referral pathway aims to accelerate the diagnosis in patients with symptoms that may suggest cancer. Early diagnosis may mean more effective treatment and a better outcome.

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 a patient's age, gender 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, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system for completing clinical audits. The practice showed us four clinical audits that had been completed in the last two years. Three of these audits were completed, and one was being re-audited at the time of inspection. Where relevant, the audits had been revisited to ensure that outcomes for patients had improved. An example was an audit into patients who had been seen at the practice with symptoms that suggested a throat infection. The audit evaluated the outcomes of patients in that group based on a Centor Score. The Centor Score is mechanism of estimating if the symptoms of a sore throat

Good

Are services effective?

(for example, treatment is effective)

are caused by a viral or bacterial infection. The clinician would award a point for the presence of a particular symptom or clinical finding, the higher the score, the higher the risk of a bacterial infection. A bacterial infection would require antibiotics to improve the illness. The first audit in December 2013 revealed that 41% of patients had been given antibiotics in accordance with NICE guidance, three patients had returned to the practice as their symptoms had not improved. Information on the audit was shared with the practice team and the NICE guidance discussed. The audit was repeated in February 2014 and revealed that 62% of patients had been given antibiotics based on NICE guidelines. We saw that no patients had returned to the practice with the same symptoms, this suggested that their illness had been treated more effectively at the initial appointment.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice held monthly meetings and reviewed their QOF performance and referral rates. We saw minutes of meetings that showed patient outcomes were regularly discussed.

The practice supplied data showed that 81% of patients on the practice register for dementia had received an annual review. A GP told us this would include a review of the patient's physical health and would take into account the personal needs of the patient. Fifty-one percent of patients on the practice register for learning disability had been reviewed. An ANP told us that the practice had been proactive in attempting to review patients in this group. They commented that the practice offered longer appointments to ensure the review was comprehensive and as not to make the patient feel rushed. The ANP also offered visits to patients in this group in their own home if this made them feel more comfortable with receiving a health review. The practice data also showed that 87% of patients at the practice on the register for poor mental health had been reviewed during the last year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions were 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 used. The practice IT system flagged up relevant medicine's alerts. . We saw the GPs reviewed the alert and use of the medicine in question and, where they continued to prescribe it outlined the rationale for its continued use. . 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 implemented principles of delivering appropriate care to patients who were approaching the end of their life. 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.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar practices in the area.

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 training courses such as basic life support. We noted a strong skill mix among the GPs with some having additional qualifications in clinical areas. For example paediatrics (care of children) and family planning. Four of the GPs were designated GP trainers, to support doctors at registrar level training to become GPs. 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 where objectives were discussed and documented. The practice had provided training for doctors at registrar level to become qualified GPs. Two of the GP partners at the practice had been former GP trainees at the practice. We spoke with a registrar GP trainee during our inspection. They were positive about the support and care provided at the practice.

ANPs and practice nurses had defined roles in managing and supporting the care and treatment of all groups of

Good

Are services effective?

(for example, treatment is effective)

patients. The nursing staff we spoke with demonstrated high levels of knowledge surrounding the care of patients that they were involved with. A practice nurse told us about the support and treatment given to patients who have diabetes. They spoke about the advice provided to patients in this group including pain relief medicines. We found this was in line with best practice guidelines. We saw the training records of the ANPs and practice nurses and noted that all held additional training and many held higher level educational qualifications.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice had an effective and robust system in place for handling and taking action on information received from local hospitals, out-of-hours providers and the 111 service. The information received was both in an electronic or paper format. A GP told us the number of communications frequently exceeded 200 in total each working day. An ANP held a role specific duty to review each communication and took responsibility to arrange any action required.

All patients on the practice register as being at high risk of admission to hospital received follow up on discharge from hospital. An ANP told us this enable the practice to reassess a patient's needs to ensure that they were being met.

The practice held a number of multidisciplinary meetings to discuss the needs of patients who had complex needs, for example patients approaching the end of their life or children who were on the at risk register. Meetings were held on a monthly basis and included all staff that were relevant to the care of patients. For example the multidisciplinary team meetings were held with the community matron, district nurses and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. An ANP held responsibility for sharing relevant information with the out-of-hours provider, for example details of patients receiving end of life care. Electronic systems were also in place for making referrals, and the practice made all possible referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and this was planned to be fully operational by July 2015. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. An example of this was that 81% of patients with dementia had received an annual health check. A GP was able to offer an example of when a patient's capacity and been reassessed and their care plan adjusted to suit their needs.

Patients who experienced poor mental health and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more

frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We reviewed practice records which showed that 87% of patients on the register for poor mental health had been reviewed in the last 12 months. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The practice manager had designed a computerised template to assist clinicians to record a patient's consent for minor surgical procedures. The template included a flow chart for clinicians to follow to ensure that consent for a procedure had been gained. The computerised template and associated coding allowed the practice to audit the consent rates for minor surgical procedures. The practice manager told us that the practice was in the process of auditing consent and had introduced the new system as they had highlighted that the documentation of consent had not been effective in the past.

Health promotion and prevention

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

Data from the Office for National Statistics from 2012 had placed Tamworth as having one of the highest teenage pregnancy rates in England. The results showed that that the pregnancy rate per 1,000 females between the ages of 15 to17 was 44. This was significantly higher than the local average of 28.9, regional average of 32 and England average of 27.7. The practice's own data showed a pregnancy rate of 21 per 1,000 this was significantly lower than the local average. The GP told us the practice could not be sure for the reasons as the data required further evaluation. They told us that one of the GPs specialised in family planning. All ANPs and practice nurses provided contraceptive advice and offered sexual health screening at the practice. All clinical staff provided free contraception where appropriate. In the three quality and outcomes framework (QOF) indicators for contraception the practice had performance rates 5% higher than the CCG and national average and had achieved 99.6% of the maximum awarded points.

The practice's performance for cervical smear uptake was 82%, which was better than others in the CCG area.

The practice offered opportunistic advice to patients that may improve their health or the condition they experienced. For example patients with long-term conditions such as chronic obstructive pulmonary disease (COPD) were encouraged and supported to stop smoking. COPD is a collective term for a number of lung diseases that cause reduced lung function and give symptoms including of shortness of breath and wheezing. We saw practice data that showed 47 patients had been supported to stop smoking in the last year. The results showed that 25% had stopped smoking at four weeks and 17% had stopped at 12 weeks. All practice nurses had completed training in supporting smoking cessation.

The practice had a recent blood pressure reading recorded in 93% of patients of a working age. A practice nurse told us that any abnormal blood pressure findings were followed up with a GP. High blood pressure is a known risk factor in serious illnesses such as stroke, and coronary heart disease.

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 above average for the CCG. For example the latest available QOF data from 2013 to 2014 showed that 99.3% of two year old children had received the measles, mumps and rubella (MMR) vaccination, the CCG average was 97.5%.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also comparable with the local and national average in its satisfaction scores on consultations with doctors with 95% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

Patients at the practice rated the care given by the practice nurses highly. The national patient survey we reviewed showed that satisfaction scores were significantly above both the local and national average. For example 90% of practice respondents said the nurse treated them with care and concern and 98% of respondents said that they had confidence in the nurse who treated them.

We asked patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 19 completed cards and the majority were positive about the service experienced. Most patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. A total of 16 cards mentioned the high level of care provided by practice staff. Two cards were less positive and commented that on occasion some GPs or receptionists could be rude.

We spoke with 13 patients during our inspection. The majority described practice staff as caring, helpful and compassionate. Two patients commented that although they thought the receptionists and GPs were caring, they felt some could be rude occasionally. All of the patients we spoke with said they had confidence in their care and that they were treated with dignity.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in another part of the office which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced 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.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients at the practice responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results showed that respondents rated the practice at higher satisfaction levels than the local and national average in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. We also saw that the satisfaction levels with practice nurses in those areas were in line with or just above the local and national averages. For example 81% of practice respondents felt the nurse had involved them in their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also very positive and aligned with these views.

Good

Are services caring?

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

A GP told us about the involvement that patients had in their own care. For example patients who had dementia received an individualised care plan that took into account their individual personal and medical needs. The care plan was reviewed at least annually and more often if required. The GP told us that the patient and their relative or carer had a central involvement in planning their care and they could give instruction on their wishes for the future if they lost the ability to communicate this for themselves. An example was recording the details of a relative or friend as an advocate who could communicate with the GP on behalf of the patient if the patient was unable to do so.

Patient/carer support to cope emotionally with care and treatment

All of the GP national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88% of respondents to the national patient survey said they felt that the GP who treated them, did so with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients registered were able to complete a form to allow the practice to share information with a carer and could specify specific details that they did not want disclosing. Carers were offered referral to an external agency for a carers assessment as a chance to discuss their needs and be offered support if appropriate.

Families who experienced a bereavement were contacted where appropriate. A GP told us based on the individual circumstances a GP would call the families if appropriate. 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.

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. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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.

The practice offered extended appointments when reviewing patients who needed additional time. An example of this was patients with a learning disability. A GP told us this was to ensure they had sufficient time to discuss issues, so the patient would not feel rushed, also to accommodate the assessment of health conditions that patients in this group were at a higher risk of developing.

Patients had access to home visits where appropriate and patients we spoke with on the day of the inspection confirmed they could request a GP home visit if needed. A member of administrative staff dealt with all requests for home visits. We saw this system in operation on the day of inspection and saw that requests for home visits were dealt with professionally and promptly. We spoke with the member of staff who held the role of home visit coordinator. They told us that the system gave continuity for patients or people calling on behalf of patients. They also commented that it gave them a greater knowledge of patients who required a higher number of visits, for example those with end of life care needs. The staff member told us they felt having a greater knowledge of these patients, reduced the number of times patients or their relatives needed to explain the history of the patient's condition and visits to a different member of practice staff each time.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. An example was the purchase of higher chairs with raised arms to assist patients and visitors with mobility issues to be able to stand from sitting more effectively.

Tackling inequity and promoting equality

The practice had access to telephone translation services for patients who did not have English as their first language.

Facilities at the practice for the consultation and treatment of patients were situated on the ground and first floor. There was a lift available for patients and visitors if they needed to visit the first floor. The practice had recently purchased new wheelchairs on both floors for patients to use within the building. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. There was a hearing loop available for patients and visitors with hearing aids.

The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity.

Access to the service

The core opening times of the practice were Monday to Friday 8am to 6:30pm, during this time the telephone lines and reception desk were staffed. The practice offered extended appointments which benefited patients of a working age and children of school age, from 7am to 8am on a Wednesday and Friday also from 6:30pm to 7:45pm on a Thursday.

The Care Quality Commission (CQC) comment cards received and the patients we spoke with offered mixed views regarding- their experience of contacting the practice and making an appointment. . We spoke with 13 patients; three described the availability of appointments as good. The remaining 10 patients told us they had experienced different levels of difficulty in obtaining planned future appointments. The practice manager and a GP told us that they were aware of patient dissatisfaction with appointment availability and the difficulties with the previous telephone system at the practice, which was a non-local number. They told us they had acted upon this by re-introducing a local telephone number and they had increased the number of staff to answer telephone calls.

Good

Are services responsive to people's needs?

(for example, to feedback?)

This included the phone system searching for members of non-reception staff that were available to answer calls. Patients we spoke with on the day of inspection said the system for telephoning had improved with the changes made by the practice. The practice manager explained the methods used of releasing some appointments each day and allowing future booking. They also told us they planned to conduct a patient survey about appointments..

Patients were able to book appointments with a preferred GP up to two weeks in advance. We saw that all GPs had routine appointments available in the following two weeks, although we saw that appointments were becoming limited despite being released that morning. All of the patients we spoke with told us that they had been able to access an on the day appointment or telephone contact with a GP if they needed it.

Appointments could be booked in person, via telephone or via an internet appointment system for patients who had registered their details for this method.

Telephone consultations were available for each GP at allotted times throughout the day. A GP commented this was particularly useful for patients with work commitments.

The practice manager told us that the practice had experienced a high number of patients who do not attend (DNA) booked appointments. For example, an audit of appointments taken in December 2014 revealed that out of 4,985 appointments made at the practice, patients did not attend a total number of 309. The practice manager told us this amounted to over 51 hours of a GPs time in a month. The practice had introduced text messaging reminders to be sent to patients the day before an appointment and had recently introduced a 24 hour line with an answering machine to allow patients to leave a recorded message to cancel an appointment. This allowed staff to monitor messages that had been left out of working hours as soon as the practice was open.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, their telephone was transferred to the 111 service. Information on the out-of-hours service was provided to patients on the practice website and in the waiting room.

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.

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room, practice booklet and on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received 20 recorded complaints in the previous 12 months. We saw that all of these complaints had all been dealt with in a timely and open way. Twelve complaints related to difficulty in contacting the practice by telephone. Following the introduction of the telephony changes made by the practice they had received one complaint.. The other 11 complaints about telephone access related to the previous telephone system used at the practice.

We saw evidence that where appropriate, lessons had been learned from individual complaints and where appropriate an apology had been issued.

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 did not have a written statement of a vision or values. The practice manager told us this was an area that they wanted to work on with the practice team. All of the staff we spoke with were able to describe the essence of what high quality empathetic patient care meant to them and their role in relation to providing it.

The practice manager also described the practices plan to introduce a longer term business plan to develop the practice in the future.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff on the computer desktop. We looked at six of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The practice held clinical meetings every two weeks and governance was discussed at each. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed. The practice held a number of other regular meetings including safeguarding, clinical governance and serious event reviews.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk assessment document which had been undertaken in previous months and addressed a wide range of potential issues, such as the loss of electrical power. We saw that recent work had been carried out to minimise identified risks. An example was extending chaperone training and criminal records checks through the Disclosure and Barring Service (DBS) to ensure that staff at the practice who did not work in a clinical role who may encounter an emergency situation or be asked to supervise a waiting area had been fully vetted.

Leadership, openness and transparency

There was a well-established leadership structure at the practice. We saw that leadership was strong and directional from both clinical and administrative team members. The GP partners had a great deal of experience between them, one of the GPs had worked at the practice for 27 years. Two of the GP partners had trained as GPs at the practice. The practice felt this was a good indicator of a positive culture at the practice, as it was recognised that there was a shortage of GPs nationally and two GPs had decided to become partners following a good experience during training.

The practice manager had a high number of years' experience within the NHS and had been in post for 18 months and had made a number of changes to the operation of the practice. These included introducing a computerised template to ensure more effective documentation of minor surgical procedures and consent in patient records.

The staff we spoke with told us that they felt able to approach the GPs or practice manager at any time.

A GP told us the practice staff regularly met with neighbouring practices in the clinical commissioning group (CCG) to benchmark their performance also to share and learn from others.

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

Staff at the practice and members of the patient participation group (PPG) met on a bi-monthly basis to discuss issues concerning the operation of services at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The PPG had 14 members and contained members from both male and female gender. The group had recognised that they were underrepresented with members from young adult age. The group had planned to introduce a social media group to attempt to attract more members from this age range. We reviewed minutes of PPG meetings and saw that the PPG had worked with the practice to gain the views of patients by undertaking surveys. The results of previous survey in 2014 were discussed and an action plan produced with the PPG to address issues raised. For example the changing of the practice telephone number from a national to a local number, new seating and the promotion of the PPG using television screens and notice boards within the practice. A member of the PPG also attended district PPG meetings to share experiences with members of PPGs from other practices and partnership agencies.

The practice had recently introduced the NHS friends and family test. The NHS friends and family test is an

Are services well-led?

Good

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

opportunity for patients, carers and relatives to give feedback on services that provide care and treatment. In the two months since the introduction of the test 90% of patients felt the service was good or very good.

We spoke with staff who gave us examples of changes to working practice following suggestions of improvement. For example, we spoke with a member of administrative staff who had suggested that the practice introduce a designated member of staff to deal with requests for home visits. Previously this was done by a number of staff and on occasion had led to patients, relatives or carers explaining the same information to a number of different staff members. The practice had introduced this method and the member of staff told us that this had improved continuity for patients, relatives and carers who requested home visits.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a training practice and provided opportunities for registrar trainee GPs to become GPs. We saw that four GPs were approved GP trainers and that the practice had provided numerous opportunities for trainees to develop their skills under supervision.

The practice team discussed ways that they could improve the service at regular meetings. One example was performing root cause analysis on patients who had been on the practice register for admission avoidance. If a patient was admitted to hospital, staff looked at the contact they had with the patient before admission and reflected on what, if anything they could have done better.

The practice manager had implemented a computerised minor surgery template to help ensure that the coding of the procedure and the obtaining of a patient's consent was recorded. This was implemented following reflection that coding and consent could be documented more effectively.

The practice had completed reviews of all significant events, complaints and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients. For members of staff not able to attend meetings, minutes were taken and placed in the staff room.