Central Milton Keynes Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Central Milton Keynes Medical Practice on 12 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, safe, well-led, and responsive services specifically for older people, those with long term conditions, patients with mental health problems and those whose circumstances make them vulnerable.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw an area of outstanding practice:

- The practice had employed a nurse who was based at the local probation office to carry out health checks. This work was a pilot project with Public Health England . The nurse carried out health checks on people on probation and offered advice and support on a variety of health promotion topics, such as sexual

health and health eating. They advised patients how to register with a GP and if any abnormalities were found as a result of their health assessment the nurse would contact a practice with their permission to facilitate registration and ensure their health problem was dealt with. They would also contact other specialist services for sensitive issues in sexual health with the patient's consent. The practice had carried out 96 health checks on these patients who were otherwise unlikely to have attended a GP for any health promotion services.

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

Importantly the provider should:

- Carry out an audit for infection control.
- Review any out of date policies.
- Ensure that audit cycles are completed to determine if actions had been effective.
- Ensure that signage in the reception area advertising the availability of an interpreter is in other languages.
- Make details of the complaints procedure available in the waiting area.
- Carry out a DBS check on any reception staff who could be asked to chaperone.

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 patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. They were involved in a variety of pilot projects, one of which provided an in-depth well-being assessment by a social worker of patients at high risk of admission to hospital, which included older patients, those from vulnerable groups, those with mental health problems and those with long term conditions. These assessments used an integrated approach to care involving social aspects as well as medical care and as such referral to a wide variety of tailor made support and enabled a more realistic assessment of the issues which affected patients on a daily basis. The practice reported 140 assessments in patients own homes which had generated 18 referrals to other NHS services and 64 to other agencies and adult social care. Other projects involved improving access and services to patients on probation who may not have sought health advice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly in all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples and comments left by

Summary of findings

patients on comment cards to demonstrate how patient's choices and preferences were valued and acted on. Patients also expressed personally to us during our inspection their high satisfaction with the caring, compassionate staff and kindness they received at the practice and how they felt safe and involved in their care. The practice also worked closely with other agencies and hosted a monthly drop in session from Carers Milton Keynes, the local MIND organisation and AgeUK for carers, those with mental health issues and the elderly to access support and advice.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with 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 evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were 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, and regular performance reviews were planned to take place shortly. Staff also 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. All older patients had their own named GP and the practice had been innovative in their approach for caring for older people. They had become involved in projects to provide a more personalised integrated approach to care in patients' own homes and identify and address risks to older people carrying out in depth well-being assessments in older peoples home to assess the risks they encounter in their own homes on a daily basis. They also hosted monthly drop in sessions run by AgeUK for patients to access support and advice.

The practice offered 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 long-term conditions. This group of patients were also included in the project to provide personalised integrated care and help patients manage their condition at home. The practice had implemented systems to provide better access to a health professional and more rapid access to medical care at home if required. This had allowed patients' health issues to be dealt with promptly and achieved access to specialist services at the hospital and facilitated the patients return home and prevented unnecessary admission as they were dealt with early in the day and had not had to wait for the GP to visit after their surgery. Whilst the project was yet to be formally evaluated the practice reported their admissions to A&E were reduced.

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 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,

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for example, children and young people who had a high number of A&E attendances. Immunisation rates were 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 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 registered patients who were homeless or sleeping rough. They had employed a nurse who was based at the local probation office to carry out health checks which was part of a pilot project with Public Health England. The nurse carried out health checks for people on probation and offered advice and support on a variety of health promotion topics, such as sexual health and healthy eating. They advised patients how to register with a GP and if any abnormities were found as a result of their health assessment the nurse would contact a practice with their permission to facilitate registration and ensure their health problem was dealt with. They also contacted other specialist services for sensitive issues such as sexual health with the patient's consent. The practice had carried out 96 health checks on these patients who were otherwise unlikely to have sought health promotion services.

There were also proactive in identifying patients in this group who may have been experiencing mental health problems and offered a well-being assessment.

The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients received a follow-up.

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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. They engaged with MIND and worked on specific projects which were proactive in providing wellbeing checks for patients with depression or mental health diagnosis. The practice had also hosted monthly drop in sessions run by MIND which patients could access to gain support and advice.

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. 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 patients on the day of our inspection and we collected comment cards from the practice that patients had left for us. We also spoke with a representative of the patient participation group (PPG) and looked at comments from the patient survey.

There were 17 comment cards left at the practice. We noted that 15 of these contained positive comments and expressed satisfaction with the service they received from the GPs, nurses and reception staff. We spoke with 14 patients who had attended the surgery that day. Patients told us that they received excellent care and were treated with dignity and respect and that they felt safe. Some patients we spoke with told us that the only concern they ever had was difficulty in getting an appointment but that the care was always good. This was also mentioned on the some of the comment cards.

The chair of the PPG confirmed that obtaining appointments was the main issue for patients and reported that patients queued in the mornings from 7.30am. They told us that the practice worked well with the PPG but that sometimes changes agreed could take some time to be implemented.

The majority of patients we spoke with told us of the benefit of being able to see their own named GP and they would prefer to wait longer for an appointment in order to do this. However, they told us they could always get an appointment if they needed one provided they were prepared to see any of the GPs available.

Areas for improvement

Action the service SHOULD take to improve

- The practice should carry out an audit for infection control.
- All policies which are out of date should be reviewed.
- The practice should ensure that audit cycles are revisited to determine if actions had been effective.
- The practice should ensure that signage in the reception area advertising the availability of an interpreter is in other languages.
- The practice should make details of the complaints procedure available in the waiting area.
- Carry out a DBS check on any reception staff who could be asked to chaperone.

Outstanding practice

We found the practice to be outstanding in the following area:

- The practice had employed a nurse who was based at the local probation office to carry out health checks. The work was part of a pilot project with Public Health England. The nurse carried out health checks on people on probation and offered advice and support on a variety of health promotion topics, such as sexual health and healthy eating. They advised patients how to register with a GP and if any abnormities were found as a result of their health assessment the nurse would contact a practice with their permission to facilitate registration and ensure their health problem was dealt with. They also contacted other specialist services for sensitive issues such as sexual health with the patient's consent. The practice had carried out 96 health checks on these patients who were otherwise unlikely to have sought health promotion services.

Central Milton Keynes Medical Centre

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, a specialist advisor who was an experienced practice manager and an Expert by Experience. This was a member of the team who was a patient from another area with previous experience of health care who was able to speak with staff and patients regarding their experiences of the practice.

Background to Central Milton Keynes Medical Centre

Central Milton Keynes Medical Centre is a GP practice which provides primary medical services to a population of approximately 16,700 patients in Central Milton Keynes and surrounding areas with specific postcodes in Bradwell Common, Heelands, Oldbrook, Conniburrow, Bradwell Village, Campbell Park and Loughton. There is a wide ethnic mix of patients from eastern Europe, Asian sub continents and Africa. Primary medical services are provided under a personal medical services (PMS) contract, which is locally agreed between the practice and NHS England.

The practice has nine GP partners both male and female and one salaried GP. The nursing team consists of four practice nurses, a nurse practitioner and two health care assistants. The practice have also recently employed a paramedic and social worker to carry out work involving patients with complex care needs as part of a specific project to improve outcomes for this group of patients. There is a practice manager and a number of administrative and reception staff who support the practice, including an office manager and an information technology manager. The practice is a training practice and supports doctors training to be GPs.

When the practice is closed services for out of hours care is via the NHS 111 service.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?

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- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, such as the local clinical commissioning group and NHS England.

We carried out an announced inspection on 12 February 2015. During our inspection, we spoke with a range of staff, including GPs, nurses, the practice manager, information technology manager, office manager and reception and administrative staff. We spoke with 14 patients who attended the practice and observed how staff dealt with patients and their relatives during this time. We reviewed comment cards which patients had left in the reception area for us where they had shared their views and experiences of the service. We also met with the chair of the patient participation group.

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. For example, there had been a medication error due to patients having similar names. We saw from minutes that this had been investigated and discussed at a clinical meeting.

We reviewed safety records, incident reports, the complaints folder and minutes of meetings where these were discussed for the last year which showed that the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice manager kept the file of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed as and when they occurred and we saw minutes from a clinical meeting where these had been reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and were encouraged to do so but we noted that meetings were in the main attended by clinical staff. Administrative and reception staff were able to explain the process for when a significant event occurred and confirmed that they were informed of outcomes of investigation. We noted that whilst only clinical staff attended the meetings where significant events were discussed, the administrative staff told us that if any event involved them they were notified by the practice manager.

Staff completed incident forms when a significant event occurred and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked a sample of incidents and saw records showing the action log which was dated and completed in a timely manner. We saw evidence of action taken as a result, for example, the practice had alerted GPs to the need to be more vigilant when dealing with patients at high risk of conditions specifically related to their ethnic origin. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received by the practice manager and practice nurse and cascaded to the appropriate staff. Staff told us that they received these and actioned as required and were able to provide an example of a recent alert they had received regarding medication.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw that the practice had an alert on the clinical system which showed vulnerable adults and children at risk of abuse. Staff we spoke with told us that they had received training in safeguarding and we saw from training records that this had taken place. The practice had a nominated lead GP for safeguarding who had undertaken the appropriate training to carry out this role. Staff were able to tell us how they would 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. They showed us that there were details on the computer regarding contacts for safeguarding and we saw that contact details for safeguarding at the local authority were also available in the waiting room.

We saw that there was a chaperone policy and that notices were in the practice to inform patients that a chaperone was available if required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Only

one of the reception staff had a Disclosure and Barring Service check. The practice manager told us that they were the main person who would act as chaperone but other reception staff were trained to chaperone. They told us that staff would never be left alone with patients.

Medicines management

We spoke with the nurses and found that there was a robust process for checking medicines stored in the treatment rooms and medicine refrigerators. We saw they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and all staff were aware of how to receive delivery of vaccines and maintain the cold chain.

Processes were in place to check medicines were within their expiry date and suitable for use and we checked a sample of medicines and found that they were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and told us that she received supervision and support from the GPs in her role. She told us that she sought updates in the specific clinical areas of expertise for which she prescribed as she identified as necessary.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. There was a policy for monitoring patients receiving high risk medicines, which we noted was out of date and required review. However, we saw that the patients had been managed appropriately.

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 also offered electronic prescribing which allowed patients to nominate their preferred pharmacy where their prescriptions would be delivered.

Cleanliness and infection control

We observed the premises to be clean and tidy and saw that there were cleaning schedules in place and cleaning records were kept. Each room had a cleaning schedule which showed the required procedures necessary and at what intervals and we saw that they had been completed. The practice employed external cleaners to manage the cleaning of the practice and we saw records to show what they were contracted to carry out each week. The practice manager told us that they also did a daily walk around the premises to assure themselves that the standards were adequate. 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 training in infection control policy. All staff had received training about infection control specific to their role and received annual updates. We saw evidence of an audit carried out in October 2012 but there was no evidence that a subsequent audit had been undertaken to ensure that actions had been carried out. There was an infection control policy but this required review and updating.

Personal protective equipment including disposable gloves, aprons and coverings 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We saw 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.

The practice had a legionella and water safety risk assessment carried out in 2013 and was to be reviewed in April 2015. Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw that work had been carried out to pipework in response to

the audit and that there was a member of staff responsible for carrying other actions, for example, flushing of the taps. We looked at documentation to confirm this had been carried out daily.

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, calibrated and maintained regularly and we saw equipment maintenance logs and other records that confirmed that this had been carried out in September 2014. This included equipment such as blood pressure monitors and spirometers. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

The practice manager told us that they were currently updating all staff records and implementing improved systems for recruiting and appraisal. The practice manager had been in post only 18 months and told us that all new staff had been subject to the new recruitment system. We saw that the recruitment process involved, for example, two references, Disclosure and Barring Service checks (DBS), photographic identification, qualifications and proof of professional registration. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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.

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 that there was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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 practice manager told us that they routinely walked around the building to check for any issues. They also told us that prior to a new filing system they had instructed a structural engineer to ensure the strength of the flooring was sufficient. There were also systems to check the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy which staff were advised to read in the employee handbook.

Risks were identified individually and assessed. Each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Practice reception staff we spoke with told us that if any patients who required urgent medical attention, for example, children who are ill, or an elderly patient, they would contact the doctors on duty to get a consultation. They also told us that they had a panic button in reception which alerted all staff in the building if there was an emergency.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and staff told us that they had undergone training. Emergency equipment was available and stored behind the staff reception area away from the public access. This included oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly by the nursing staff. All clinical staff had received cardio-pulmonary resuscitation training to deal with emergencies.

Emergency medicines were available in the emergency trolley and easily accessible to authorised staff. All the staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

Good

Are services safe?

hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw that a business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Whilst we noted that the policy required review and updating, the required risks were rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety and we saw that a fire drill had been carried out in January 2015. We looked at records which showed that staff were had received fire training and there was a specific fire warden.

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 were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. 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.

From discussion with staff we found that GPs each had specific clinical areas on which they were the lead specifically for the Quality and Outcomes Framework domains (QOF), for example diabetes, chronic heart disease and asthma. We saw from minutes of clinical meetings that these areas were discussed to determine whether good progress was being made or where additional focus and resource was required. We saw that the practice nurses supported this work, which allowed the practice to focus on specific conditions. All clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The nurses reported having good communication with the GPs overall and could discuss issues about patients at any time. They felt supported to manage patients with chronic conditions and refer to GPs when appropriate. Staff showed us how they registered patients with specific conditions and provided information materials as well as signposting to support groups.

We discussed data from the local CCG of the practice's performance for antibiotic prescribing, which had been higher compared to similar practices. However, we saw from minutes of a meeting that the practice had discussed the change of medications and that the nursing staff had been involved and a change enacted. The practice had also completed a review of case notes for patients with conditions such as epilepsy and heart failure to ensure the appropriate treatments were in place.

The practice had been involved in a pilot of specific funded projects to determine if the implementation of detailed well-being assessments in patients own home and subsequent support to identified needs would improve care and outcomes for older patients and reduce the risk of admission to hospital. They had introduced an integrated care plan model, whereby they had employed a social worker and community nurse to work alongside other nursing colleagues to provide better assessment and support in patients own homes. The social worker carried out well-being assessments in the patient's home and any patients who had been identified as a high risk of admission would have a response the same day from the GP or relevant clinical person. They would be referred to the nurse if they had unmet health needs for further assessment or referred to other organisations if appropriate.

They used the electronic Frailty Index (eFI) to identify patients at risk and whilst the project focussed on older patients, it also encompassed patients sufferings with mental health problems and long term conditions and allowed a more holistic assessment of all aspects of health, for example, identifying dietary deficiencies, hazards in the home, and lack of financial benefits. It also provided a more co-ordinated approach to care with involvement of a variety of support services.

The practice told us that they had good communication with the district nurses who were based in the practice, as well as with the community matrons. The service was to be evaluated fully but the practice manager told us of initial positive feedback from patients and provided several examples where patients had benefitted. For example, they had identified a safeguarding issue which would not have been noticed if assessment had not been in the patients home. There was also an example of referral to support services for patients who had suffered bereavement and subsequent depression and not felt able to seek help themselves. The practice reported 140 assessments in patients own homes which had generated 18 referrals to other NHS services and 64 to other agencies and adult social care.

The practice had also secured funding for another project to reduce hospital admissions. They had employed a paramedic to work in the practice one and a half days a week who would triage patients and carry out a home visit if necessary. If they felt assessment was required in a

Good

Are services effective?

(for example, treatment is effective)

hospital setting they would arrange this early in the day to help facilitate return home the same day and prevent hospital admission. At the time of our inspection the projects had not been officially evaluated. However, the practice manager told us that their hospital and A &E attendance was always below budget compared with other practices in the clinical commissioning group.

The practice manager and senior partner told us that they were trying to undertake more preventative work and had become involved in a mental health project with MIND where well-being assessments were offered. The practice had written to patients suffering with depression or a mental health diagnosis to invite them for well-being checks asking. The practice manager told us that they have received many positive comments from patients regarding these drop in services.

The practice told us that there was good communication between all of the staff involved in all of the projects helping to provide a more co-ordinated approach to care.

The practice used other computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. For example, the SystmOne highlighted patients 'at risk' such as those with dementia. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP in a timely way. We noted that if a doctor was away on leave they had a 'buddy' system in place to ensure important information was dealt with promptly.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The GPs told us that equity and diversity training was a part of the requirement of being a trainer and they had undertaken this.

Management, monitoring and improving outcomes for people

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

The practice showed us several clinical audits that had been undertaken in the last two years. We saw that some of these had resulted in change of practice. For example, antibiotic prescribing and management suspected urinary tract infections. The practice also carried out other audits in response to safety alerts and other areas when deemed relevant. They showed us evidence of an audit in progress regarding prescribing of medicines used in epilepsy. We saw minutes of clinical meetings to show that the results of audit had been shared with the practice and plans for change in practise discussed. Whilst audit was completed and changes implemented and shared we found that they were not revisited later to determine the effectiveness of change and therefore the cycle was not complete.

The GPs told us clinical audits were often linked to information 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). For example, we saw an audit regarding the prescribing of analgesics and respiratory medication.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had a higher than the CCG and national average achievement in all clinical areas of the QOF with the exception of arterial disease. These included areas such as, chronic obstructive pulmonary disease, asthma, heart disease and diabetes,

Following discussions with staff and looking at minutes from meetings we found that the team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice told us that one trainee planned to be involved with a research project concerning cancer diagnosis.

Staff we spoke with demonstrated that they were clear regarding the processing of repeat prescribing and there was a protocol in place. However, this was out of date and required review. They also checked that all routine health checks were completed for long-term conditions such as

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Are services effective?

(for example, treatment is effective)

diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant alerts when the GP was prescribing medicines. We saw evidence to confirm that the GPs had an organised recall system and utilised the clinical system to highlight needs which showed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and held multidisciplinary meetings every three months to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services 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 mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nurses and saw that nurses had additional training in areas such as diabetes, cytology, minor injury, smoking cessation and wound care.

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

The practice manager told us that they were updating and renewing all staff files and introducing new appraisal documentation. We saw from staff files that this process was in progress. As a result appraisals had not yet been carried out this year. However, the practice manager confirmed that they were currently organising the appraisal schedule. We spoke with staff who told us that they normally had regular appraisal and were aware that these were to be carried out soon. Staff reported that they were able to identify areas of development at any time of the year and not just at appraisal. The nurse practitioner told us that they had an appraisal with a specific GP and that the practice supported training identified. For example, the practice had supported them to undertake the nurse practitioner degree course.

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, minor injury and wound care. We saw that nurses with extended roles for long term conditions such as diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

We saw that the practice had worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a system in place of dealing with these in that the responsibility is that of the patients registered GP to deal with letters and communications. If the GP was going to be away then the practice had a buddy system to ensure that communications were dealt with in a timely way. We saw an example of how this had worked well. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for processing hospital communications was working well in this respect.

The practice also hosted an HIV testing service which was provided by another organisation who attended the practice to offer HIV testing to patients who may be at risk.

The practice held multidisciplinary team meetings every three months 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

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Are services effective?

(for example, treatment is effective)

district nurses, social workers, palliative care nurses and 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.

We found from discussions with the practice manager and staff that the practice had worked with support organisations, specifically, AGE UK, MIND and Carers UK. The representatives from these organisations were attending the practice to offer support to patients who required it. We saw posters indicating when patients could access each service representative over the following months. The practice manager told us that this had been received well by patients and carers and they had observed significant numbers taking up the service.

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. Electronic systems were also in place for making referrals. The practice referred via the referral management system that used the Choose and Book facility. (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. The practice had signed up to the electronic Summary Care Record. (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 using SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system and the practice had a lead in IT who dealt with the training in this. Staff commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it but had not had formal MCA training. 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. The practice staff told us that they discussed issues with colleagues and the multi-agency safeguarding hub (MASH). The GPs were able to describe a recent concern and how they had dealt with it which was appropriate.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing with the nurse and reviewed annually by their individual GPs. Staff gave an example of how a patient's best interests were taken into account when a patient did not have capacity to make a decision and the appropriate action was taken. 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 had a standard form for documenting consent for specific interventions. For example, for all minor surgical procedures.

Health promotion and prevention

The practice had 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.

It was practice policy to offer a health check with the health care assistant 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and invited patients for an annual physical health check.

The practice's performance for cervical smear uptake was 89%, which was higher than others in the CCG area and we saw that they had a good call and recall system in line with national guidance. The practice had a 'pod' situated in the surgery which allowed patients to record their blood pressure and weight in the waiting room and this was transferred to their care record. Results were reviewed by the nurse the following day and any necessary action was carried out.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and the practice had a good uptake for these services. The practice offered child health checks at eight weeks prior to immunisation.

All older patients had their own named GP and the practice was proactive in identifying patients at greater risk of admission to hospital and had taken part in a project to identify and offer additional support to these patients. They had employed a social worker to work with nurses to carry out assessment in their own home. If any risks were identified they were responded to on the same day. This had not been evaluated at the time of our inspection but it was planned that evaluation would be carried out at the end of March.

The practice had a robust approach to management of long term diseases specifically chronic obstructive airways disease and asthma. These were reviewed regularly and self-management plans were encouraged for appropriate patients and referral to other services such as pulmonary rehabilitation made when necessary.

The practice registered patients who were homeless or sleeping rough. The practice had also employed a nurse who was based at the local probation office to carry out health checks. The work was part of a pilot project with Public Health England. The nurse carried out health checks on people on probation and offered advice and support on a variety of health promotion topics, such as sexual health and healthy eating. They advised patients how to register with a GP and if any abnormities were found as a result of their health assessment the nurse would contact a practice with their permission to facilitate registration and ensure their health problem was dealt with. They also contacted other specialist services for sensitive issues such as sexual health with the patient's consent. The practice had carried out 96 health checks on these patients who were otherwise unlikely to have sought health promotion services. The practice had a register of patients with dementia who were invited for yearly review and care plans were in place. Many of these patients were visited at home by the social worker employed by the practice. Patients with mental health problems were invited for health checks but the practice reported that uptake was poor. They reported that they sometimes communicated with the patient's key worker who worked with patients to encourage attendance. They had also become involved in a project with MIND and had written to patients to invite them for a well-being assessment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 14 patients on the day of our inspection. All patients we spoke with told us that the doctors and nurses treated them with respect and dignity and reported positively regarding the caring nature of GPs and all the staff. Several patients told us that the doctors gave them plenty of time during their consultation and explained their condition to them. Other patients commented that the reception staff were helpful and treated them with kindness. One patient gave us an example of when the reception staff had comforted them when they were distressed in the surgery. We saw that there was a separate room available for patients to talk privately when necessary. Other patients had commented how the doctors had supported them when they were dealing with newly diagnosed complex health conditions. All patients reported friendly, professional, kind and caring, responsive GPs and staff.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and all except two were positive about the service experienced. Patients reported that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive expressing difficulty in getting an appointment but they did report that care was good from both nurses and doctors.

We reviewed the most recent data available for the practice on patient satisfaction. We looked at the results of the national patient survey of 2014, which reported that 90% of patients who responded said that their overall experience of the practice was good. This was above the CCG average of 78%. We noted that 96% of patients felt that the reception staff were helpful compared with 86% of the CCG average. Whilst we saw that some patients had commented that getting through on the telephone was difficult at times, the patient survey showed that patients' experience of this was still better than the average of the CCG.

We saw that all consultations and treatments were carried out in the privacy of a consulting room and 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.

Generally, during our inspection we saw that staff were careful to deal with patients and maintain confidentiality. However, we did observe a member of the reception staff ask a patient sensitive information without discretion. The practice switchboard was shielded by glass partitions which helped keep patient information 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 she would investigate these and any learning identified would be shared with staff.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. Reception staff told us that they had a panic button and all staff attended if they heard it. They gave an example of when it had been used with good effect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in decisions about their care.

Patients we spoke with on the day of our inspection were positive regarding how their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Several patients told us that they liked to see their own GP and that was important to them as they took time to listen and give advice about their condition. Some patients we spoke with were new to the practice and reported experiencing good communication and being treated well. They also told us they felt listened to and supported by staff and had

Good

Are services caring?

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 positive and aligned with these views.

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, however, we noted that the signage was only in English.

Patient/carer support to cope emotionally with care and treatment

The 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, 93% of respondents reported the GPs gave them plenty of time and 86% reported that the GPs were good at explaining tests and treatments. 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 that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations such as AGE concern. The practice's computer system alerted GPs if a patient was also a carer. We saw that there was information for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered bereavement, their usual GP contacted them if it was appropriate.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The 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 were also proactive in identifying patients' needs and engaging in innovative projects to improve services for patients, such as the Better Care Fund. This was a project which helped identify patients who were older and more vulnerable and introduce a more co-ordinated approach to keep patients at home and out of hospital.

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). For example, the PPG had set out in their action plan that a new practice leaflet should be developed informing patients more clearly regarding making and cancelling of appointments. We saw that this had been completed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had access to translation services from the local authority which the reception staff booked as necessary. There were also two GPs who spoke Arabic. The practice staff told us that they registered homeless patients.

The premises and services had been adapted to meet the needs of patient with disabilities. There were electronic doors to the entrance of the practice and there were accessible toilets for all patients including disabled access and baby changing facilities for parents with young children.

The practice was situated over the ground and first floor of the building with all GP and nurse consulting rooms for patients on the ground floor. However, there was lift access to the first floors where occasional additional services took place. The practice had wide corridors which made movement around the practice easier for patients with mobility scooters and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Access to the service

Appointments were available from 8:30 am to 6 pm on weekdays. The practice did not offer extended hours appointments but had a duty doctor and another doctor on standby to accommodate on the day and emergency appointments. Appointments could be booked up to eight weeks ahead and on the day.

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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients if they needed them and those with long-term conditions. Patients we spoke with told us that although it was difficult to get an appointment sometimes, if they needed to see a doctor urgently then they could be seen. Whilst there was some dissatisfaction expressed by some patients on the day of our inspection regarding getting an appointment, of the 17 comment cards we reviewed only two referred to this.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. We spoke with four patients with young children who reported that they were pleased with the access they have to the service for their babies and could always be seen if their child was sick.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. It had a complaints policy and procedures

Good

Are services responsive to people's needs?

(for example, to feedback?)

were in line with recognised guidance and contractual obligations for GPs in England. We saw that there was reference to the complaints procedure on the practice leaflet and was available on the practice website. However, we noted that there was no sign or poster advertising the complaints procedure in the waiting area.

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.

We looked at the complaints folder and saw that complaints and been acknowledged and dealt with appropriately and in a timely manner. Staff told us that any concerns or complaints involving a specific member of staff would be dealt with individually. The staff reported an open and honest culture within the practice.

The practice reviewed complaints annually to detect themes or trends and whilst we did not see minutes of a meeting where the annual review of complaints was discussed we saw a summary of complaints and no themes were noted. We saw that lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. They demonstrated an innovative and proactive approach to care and commitment to development of the services they offered to patients.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All staff reported feeling involved in the practice and felt valued.

Governance arrangements

The practice had employed a new manager only 18 months previously who told us that they had been working to introduce new systems to make the practice operate more efficiently. As a result, whilst there were policies and procedures in place to govern activity some of these required reviewing and updating. These were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and procedures and those that and been updated were appropriate and fit for purpose.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding. Staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had a high achievement in all areas. 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 undertaken a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit on use of heart failure medication.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the individual risk logs for all areas such as fire and equipment. We saw that risks were discussed when necessary at team meetings and updated in a timely way.

The practice held weekly practice and partners meetings and any governance issues were addressed as required. We looked at minutes from a selection of meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that practice meetings were held weekly. These were broken down into specific topics weekly. For example, partners meeting, management meetings and clinical meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time. There was also a protected learning session every month for the whole practice where the practice closed for half a day and all staff including administration and clerical staff had a meeting or training.

The practice manager was responsible for human resource (HR) policies and procedures but had been introducing a new system and recruited the services of an independent company to deal with HR. We saw that they had a new staff handbook that would be given to all new employees. This included sections on whistle blowing, disciplinary procedures and harassment and sickness.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the patient survey, the patient participation group (PPG) and complaints. We spoke to the chair of the PPG who reported that the practice worked well with the group and responded to feedback. They did comment that sometimes changes took some time to implement. We saw from the action plan as a result of the patient survey that the practice had addressed some of the issues raised, such as the updating of the practice leaflet. They had also changed the display board in the waiting room in response to the PPG request.

The practice had an active patient participation group (PPG), however, the PPG and the practice did not consider that the PPG is representative of the practice population and needed to recruit members from a wider ethnic

Are services well-led?

Good

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

population. The practice have worked with the PPG to explore ways of achieving this, for example, advertising on the back of prescriptions and in the waiting area. We saw the results of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff we spoke with told us they felt supported and valued within the practice. They told us they felt supported to develop their skills to areas which would benefit patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals had taken place but were overdue at the present time as the practice manager was introducing a new system with documentation that they considered more suitable. The programme of appraisal was being scheduled and due to start soon. Staff told us that they had received appraisal regularly to date and were able to identify training needs at any time not just at appraisal.

The practice was a GP training practice and supported new doctors training to be GPs. We were not able to speak with any trainees on the day of our inspection.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.