# Haddenham Medical Centre

## Quality Report

Haddenham Medical Centre
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Date of inspection visit: 10 December 2014
Date of publication: 19/02/2015

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**

Haddenham Medical Centre is located in purpose built premises which opened in 2005. There is a commercial pharmacy located in the same building. Approximately 8,000 patients are registered at the practice. We carried out an announced comprehensive inspection of the practice on 10 December 2014. This was the first inspection of the practice since registration with the CQC.

Patients we spoke with were positive about the care they received. Some of the patients we spoke with were unclear about the appointment system at the practice. The practice results for the national GP patient survey 2013 were below the clinical commissioning group (CCG) and national average. The national survey had been carried out at a time of significant change within the practice. A GP had retired and locum GPs were working until a new partner was appointed. The practice had undertaken a short satisfaction survey in August 2014 and the results of this showed a 20% increase in the satisfaction ratings compared with the previous national survey.

We spoke with six patients during the inspection. We met with three members of the patient participation group. We spoke with four GPs, a GP in training and seven members of practice staff.

Haddenham Medical Centre was rated good overall.

Our key findings were as follows:

- the practice had systems in place to identify, assess and manage risks to patient's safety. Medicines were safely stored, recorded and administered and the practice was following relevant guidelines to reduce the risk of cross infection.
- GPs and nurses followed national guidelines when delivering care.
- patients we spoke with and those who completed comment cards told us care was delivered with compassion and dignity.
- staff were appropriately trained and demonstrated sound knowledge of their roles and responsibilities. Clear lines of management responsibility were evident.

# Summary of findings

- the practice responded to patient concerns relating to access to appointments and changes had been made to the appointment system.

We saw an area of outstanding practice:

- flexible appointments were available for patients who relied on voluntary transport to bring them to and from appointments enabling older patients and those from rural communities to receive medical advice and treatments.

In addition the provider should:

- introduce a system to confirm necessary action has been taken in relation to medicines alerts and other national safety alerts
- consider the introduction of a stock control log for the medicines held in the medicines cupboard.
- re-issue guidance for patients on how to access appointments and the availability of on the day appointments for urgent medical needs.
- review their policy on undertaking criminal records checks for administration staff who carried out chaperone duties.

**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. Medicines were managed safely and the practice was clean and tidy. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify appraisals for all staff. The practice worked closely with other providers of care and some visiting clinics were held at the practice.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients we spoke with and the comment cards we reviewed confirmed patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice had made significant effort to stabilise the team of GPs and nurses to deliver more consistency in care. There was evidence that patient opinion of the service was improving since the national patient survey taken in 2013. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patient survey results in the past showed that patients had not found it easy to make an appointment. The practice had changed their appointment systems to increase the opportunity for patients to

# Summary of findings

obtain medical advice quickly. There were urgent appointments available the same day and the practice offered Saturday morning clinics every other week. Patients were able to book appointments by various means either by phone, in person or online.

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. Learning from complaints was shared with staff.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear mission statement. 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 team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group (PPG) was active. Staff had received inductions and undertook regular performance reviews. The practice demonstrated a strong commitment to training.

# 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. National 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 services to support patients diagnosed with dementia and requiring end of life care. It was responsive to the needs of older people, and offered home visits and flexible appointments for those who used voluntary transport to get to and from appointments.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. Data showed the practice performed well in supporting this group of patients. Structured annual reviews to check that their health and medication needs were carried out. For those people with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had maintained clinics for this group of patients by ensuring appropriately qualified nursing staff were employed to cover staff absences.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Immunisation rates were relatively high for all standard childhood immunisations and the practice had taken action to maintain immunisations when the national recall system had experienced problems. Childhood immunisations were available on Saturday mornings to assist working families. Appointments were available outside of school hours and the premises were suitable for children and babies. We heard how the practice had worked hard to maintain midwife clinics on site. A GP visited a local school to hold education sessions with the students and their families.

**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 and flexible. Extended hours of practice were offered from 8am in the morning and the practice opened every other Saturday morning. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. Registers of both carers and patients with a learning disability were in place. Information for carers was available both at the practice and on the patient website. The practice hosted carers forums and was active in other community groups. A small traveller community lived nearby and patients from this community were registered with the practice. A named GP was allocated for patients with a learning disability.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The national targets for supporting the physical health of patients with mental health problems had been met. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

GPs were aware of the local voluntary groups supporting patients with poor mental health and had information available to assist patients in accessing these. A memory clinic was held at the practice every week and GPs were able to refer patients with early signs of dementia to this service.

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## What people who use the service say

The results from the last national patient survey, completed by 127 patients, showed patient satisfaction below that of other practices in the clinical commissioning group (CCG) area. The survey had been carried out at a time when some GP sessions were being covered by locum GPs due to both retirement and long term sickness absence of two of the partner GPs. The current GPs and management were aware that the national survey results had not been positive. Changes had been made in response to the results. A new partner had been appointed in 2012. A new practice manager came into post in 2013 and the practice had changed their appointment systems to include triage of calls for urgent appointments.

The practice had conducted a short satisfaction survey in August 2014 and the overall satisfaction rating for the practice had risen by 20%. The patient participation group were active in preparing for another survey and regularly sought the views of the local community via attendance at local voluntary and statutory forums.

We reviewed 27 comment cards that had been completed by patients attending the practice in the two weeks prior to our inspection. The comments were very positive about the care received from staff and the time patients were given to discuss their health issues. There were four negative comments which continued to focus on the appointments system. We informed the GPs and practice manager of these findings during our feedback.

The six patients we spoke with on the day of inspection were all positive about the care and treatment they received from the GPs and nurses at the practice.

## Areas for improvement

**Action the service SHOULD take to improve**

- introduce a system to confirm necessary action has been taken in relation to medicines alerts and other national safety alerts
- consider the introduction of a stock control log for the medicines held in the medicines cupboard.
- reissue guidance for patients on how to access appointments and the availability of on the day appointments for urgent medical needs.
- review their policy on undertaking criminal records checks for administration staff who carried out chaperone duties.

## Outstanding practice

- flexible appointments were available for patients who relied on voluntary transport to bring them to and from appointments enabling older patients and those from rural communities to receive medical advice and treatments.

# Haddenham 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 Practice Manager expert advisor and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

## Background to Haddenham Medical Centre

Haddenham Medical Centre provides primary medical services to the population of Haddenham Village and surrounding smaller villages. There are four partners working at the practice. Two male and two female. A female salaried GP is also employed. The practice is accredited to teach GPs in training and GPs in training are currently working at the practice. The nursing team is in transition. Currently two locum nurses work alongside an employed nurse and two health care assistants. Two nurses have been appointed and are due to start work in early 2015. The practice manager and GPs are supported by a team of administration and reception staff. The practice offers primary medical services via a General Medical Services (GMS) contract. (GMS contracts are centrally negotiated for practices across England).

The practice has the highest percentage of patients registered over the age of 65 and the lowest deprivation rates in the area. Around half of the patients registered live in the village of Haddenham. The practice takes an active role in the local community and works with an active and well supported patient participation group (PPG).

The CQC intelligent monitoring places the practice in band three. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Services are provided from:

Haddenham Medical Centre, Stanbridge Road, Haddenham, Buckinghamshire, HP17 8JX

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the website.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service on 10 December 2014 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

# Detailed findings

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

## How we carried out this inspection

Before visiting Haddenham Medical Centre we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Aylesbury Vale Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 10 December 2014. During our inspection we spoke with a range of staff, including GPs, practice nurses, the practice manager, a health care assistant (HCA) and reception and administration staff.

We observed the interactions with patients at the reception, how phone calls from patients were received and looked at the environment in which patients received care and treatment. We did not observe patient's consultations and treatments. We reviewed 27 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit. We met with three members of the patient participation group (PPG). Records relating to management of clinical conditions and others relevant to the management of the service were reviewed.

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)

The practice had the highest population of patients over the age of 65 in the CCG. The rural location of the practice, and the age of many of the patients, meant that a number of patients relied on voluntary transport to bring them to and from their appointments.

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 over the last 18 months. This showed the practice had managed incidents and complaints consistently and could show evidence of a safe track record.

**Learning and improvement from safety incidents**

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every three months to review actions from past significant events and complaints. There was evidence that the practice had learned from these. We saw evidence of action taken as a result. For example, GPs had reminded themselves of the protocol for referring patients to the orthopaedic department at the local hospital. 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. We saw evidence that patients who had raised concerns were invited to meet with either the practice manager or a GP to discuss their concerns.

National patient safety alerts were disseminated by the practice manager. These were forwarded to either the GPs or the practice nurses by e-mail. GPs we spoke with were able to give examples of recent alerts that were relevant to the management of medicines. However, the practice did not have a system to report back to confirm all relevant action had been taken. GPs were aware of their responsibility to respond to alerts relating to medicines and were able to tell us what action they took.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all GPs and staff had received relevant role specific training on safeguarding. We asked GPs, nurses and administration staff about their understanding of safeguarding. Staff knew how to recognise signs of abuse. They were also aware of their responsibilities and knew how to share information.

The practice had appointed a dedicated GP as lead in safeguarding. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. They also held a lead role for safeguarding within the clinical commissioning group (CCG). All staff were able to tell us who the lead GP for safeguarding was and where they would find the contact details of the relevant agencies if a concern needed to be reported outside of the practice. The contact details and practice safeguarding procedures were held in both a protocol file and in a shared folder on the practice computer system. There was a system to highlight vulnerable patients on the practice's electronic records.

There was a chaperone policy. All nursing staff, including health care assistants, had been trained to be a chaperone. We were told that on occasions reception staff had undertaken chaperone duties. We spoke with reception staff who had undertaken this role. They were conversant with the practice chaperone policy. They also described the role they undertook when acting as a chaperone. The description followed the practice protocol and recognised good practice. These staff had not been subject to a criminal records check. We were told that chaperones were never left in the consulting room alone with a patient. The practice should review their policy in relation to criminal records checks for administrative staff who carry out chaperone duties.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. We were told of an incident when a fridge failed. Staff dealt with the incident in accordance with the policy. The practice purchased an additional fridge as back up.

Good

# Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. We checked 20 medicines. All were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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 health care assistant told us they would never administer an immunisation without authority from a prescriber recorded in the patient's record. When opportunistic immunisation was carried out, such as flu vaccination during a routine health check, staff sought a GP to authorise the procedure and record the authorisation before proceeding.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, there was a monitoring protocol for administration of blood thinning medicines and GPs we spoke with told us how they followed this protocol.

All manual 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 kept securely at all times. The practice had adopted the electronic prescribing system (EPS) and a large number of prescriptions were sent electronically to the pharmacy from which the patient chose to collect their prescription.

**Cleanliness and infection control**

We found the practice clean, tidy and free from clutter. Cleaning schedules were in place and these were followed by the cleaners. This was evidenced by the cleaners completing weekly logs of the tasks they had undertaken. There was a deep cleaning schedule in use. This included deep cleaning of carpets, curtains and upholstery. A spare set of curtains was kept on site to ensure that privacy could be maintained around the couches in consulting rooms whilst curtains were being cleaned. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Staff we spoke with told us they had no concerns regarding the standards of general cleanliness.

Cleaning equipment was stored safely and securely in a locked cupboard. We saw that cleaning equipment was subject to separation to identify which was to be used in clinical rooms and which were to be used in other areas. Safety data sheets were held for all cleaning materials used. These detailed how to use the product and what action to take if the product was spilt accidentally. Copies of these data sheets were also held in each of the beverage preparation areas where washing up was carried out.

The practice had a lead for infection control and we saw that nursing staff had undertaken further training to enable them to provide advice on the practice infection control policy. We saw evidence the lead had carried out a detailed infection control audit in each of the last three years. The practice manager had invited the CCG lead for infection control to complete an independent audit in the summer of 2014. We reviewed the results of this audit and found the practice achieved a score of over 90% which placed them in the good category.

The practice had a contract in place for the disposal of clinical waste. Clinical waste was appropriately segregated from general waste and suitable receptacles; for example, foot operated bins and sharps boxes were in place in the practice. Waste awaiting collection by the contractors was held securely in a locked bin in a room which was only accessed by staff and we found it locked.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use. Staff told us there was always sufficient PPE available. There were records showing that staff who received specimens from patients had been trained in the safest way to take receipt. There were also records confirming that hand hygiene training had been completed by all staff. There were policies and procedures to deal with spillages of potentially dangerous fluids including bodily fluids. Spill kits were kept in each consulting and treatment room and the practice had a vacuum cleaner specifically designed to clear such spillages.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Good

# Are services safe?

The practice had a risk assessment relating to legionella (a germ found in the environment which can contaminate water systems in buildings) and other waterborne bacteria. This had been completed by a qualified contractor. There was evidence that action identified in the risk assessment report had been undertaken. For example, water tanks had been cleaned and disinfected by appropriately qualified contractors.

**Equipment**

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. The nurse we spoke with told us they only had to ask the practice manager and essential equipment was ordered immediately. We saw that treatment rooms were well stocked with equipment and that this was kept clean. Invoices we saw showed us that equipment had been maintained and serviced in accordance with manufacturer's instructions. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. There was also a record held of the test reports. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example, weighing scales.

The building and important equipment installed within the practice were subject to appropriate servicing and maintenance arrangements. For example, there was a certificate confirming the electrical system had been tested and passed safe to use. An invoice evidenced the fire alarm system had been serviced, tested and passed fit to use.

**Staffing and recruitment**

We reviewed seven staff personnel records. These contained all documentation required by legislation. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Recruitment checks had been undertaken before staff started work at the practice in accordance with the recruitment policy.

We spoke with the practice manager 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. For example, there were more staff on duty in the morning than in the afternoon to cover the higher volume of patients attending and phoning the practice.

There was evidence that staff cover had been reviewed. We heard how staff were being trained to cover various roles. For example, a member of the administration team had been trained to cover reception to increase staff flexibility. Workforce planning was evident. For example, the deputy reception manager's hours had been increased to deal with a growing workload. Minutes of meetings showed succession planning was in place as future retirements were discussed. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We saw that recruitment had taken place in advance to appoint a salaried GP to commence upon the retirement of the current salaried GP in 2015.

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.

There was a policy for recruitment of locum GPs. This included carrying out appropriate background checks, such as references, before the locum started work.

**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 regular checks of the building. Monthly checks of medicines and emergency equipment. There were equipment servicing and calibration schedules and records showed that both the building and equipment received appropriate maintenance. The practice also had a health and safety policy. The health and safety policy was supported by more detailed policies such as manual handling. All safety policies were held on a central file. Staff were aware of where all policies and procedures, including safety information, were kept.

Patients taking medicines that required special monitoring arrangements, such as those on blood thinning medicines, were called for regular blood tests. The system to advise these patients of their test results and adjust the dosage of medicine was operated effectively.

Good

# Are services safe?

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. There were records showing that the equipment was checked on a monthly basis.

Emergency medicines were available. These were held in a treatment room and all staff knew of their location. The medicines included those for the treatment of cardiac arrest and anaphylaxis. A monthly check to ensure these emergency medicines were within their expiry date was carried out and recorded. A clear record of the expiry dates of emergency medicines was held to enable staff to replace those that were reaching their expiry date. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was detailed along with the actions to take to reduce and manage the risk. Risks identified included power failure, adverse weather, and flood of the premises. We were told and saw evidence that the plan had been used to deal with a flood in the practice earlier in 2014. Services had been maintained at that time because staff knew their role in dealing with the emergency and the contingency plans had been put into action. For example, patients were redirected to enter the building via a door to a corridor less affected by the flood. The document also contained relevant contact details for staff to refer to. For example, contact details of a 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. There were records confirming that a number of staff had completed online fire safety training.

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 and from local commissioners. For example, we were shown the CCG prescribing protocol for patients with hypertension. The practice held a file on their computer system containing a range of clinical protocols. These included guidance on when and how to make referrals to hospital departments. We found from our discussions with GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The steps to follow when reviewing the care of patients with long term conditions were included in templates on the computerised patient care record.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs we spoke with were very open about asking for and providing colleagues with advice and support. There was recognition that some GPs held a greater level of expertise in certain fields of medicine. One GP undertook surgical procedures. The other GPs referred patients who could have required a surgical procedure to the surgical lead for an opinion and subsequent surgery if this was assessed as necessary. Nurses told us they could access swift advice from GPs when patients presented with more complex needs than expected.

One of the GPs showed us data to confirm the assessment and treatment of patients with hypertension followed national guidance. They also showed us a sample of patient records that evidenced the assessment and treatment had been carried out.

We reviewed data of the practice's performance for antibiotic prescribing, which was comparable to similar practices within the CCG. National data showed that the practice was in mostly in line with referral rates to secondary and other community care services for all conditions. The higher number of elderly patients registered was recognised as affecting referral rates for some medical conditions. For example, ophthalmology where a rapid access referral system was also available. We saw that the practice supported patients with early signs of dementia by referral to the visiting consultant who held a memory clinic at the practice once a week.

**Management, monitoring and improving outcomes for people**

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. We were told how the system for placing alerts on the patient record system assisted all staff in the support they gave patients. For example, when a patient was identified as requiring support to understand their treatment and results the reception staff were able to remind the patient to bring a relative, carer or advocate with them to their appointment.

The practice showed us seven audits that had been undertaken in the last three years. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Changes achieved resulting from clinical audit included increasing the uptake of a blood test linked to taking a specific medicine by 13% over a one year audit cycle. There were audits linked to medicines management. Data confirmed the practice had taken part in and achieved all the targets for medicines management set by the clinical commissioning group last year. For example, prescribing of cholesterol lowering medicines and anti-inflammatory medicines.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in managing patients' asthma, chronic obstructive pulmonary disease (lung disease) and kidney disease.

Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The IT system highlighted medicines alerts when the GP went to prescribe medicines. GPs told us how they ensured patients on repeat medicines received an annual review. We heard that patients were encouraged to book their annual medicine review as close

to their birthday as possible. This gave patients a fixed point in the calendar to arrange their medication review. The practice used the birthday of patients with hypertension (high blood pressure) as the recall point for their annual review. This also acted as a reminder to the patient that their review was due.

The practice also reviewed other performance data. For example, they were aware that the higher number of registered patients over the age of 65 affected the number of attendances at the A&E department. A review of the attendances was undertaken to identify whether A&E attendance was appropriate. Advice was offered to patients who could have used alternatives to A&E. The practice was actively involved with the CCG in the planning of a rapid intervention and enablement team to support patients at home and avoid inappropriate attendance at A&E or hospital admission.

One GP at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The GP was appropriately trained and kept up to date in any changes to national guidance. They also regularly carry out clinical audits on their results and used them in their learning.

**Effective staffing**

Practice staff included GPs, nurses, managerial, administrative and reception staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support training. We noted a good skill mix among the GPs with two having a diploma in child health and two with diplomas in obstetrics and gynaecology. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. A member of staff who had started work at the practice a month before our inspection had already completed online training on a variety of topics. These included, safeguarding of children and vulnerable adults and fire safety. This member of staff had identified a training course they regarded as relevant to their role and the course had been booked for them to attend in February 2015. The practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the GP in training we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel immunisations. The practice had appointed nurses, who were due to start work in early 2015, to take up extended roles in supporting patients with long-term conditions such as asthma and diabetes. The staff appointed were qualified to undertake these roles. At the time of our inspection these clinics were undertaken by locum nurses who were qualified to support patients with these conditions. Travel clinics had been suspended to enable nursing staff to focus on supporting the care of patients with long term conditions. The travel clinics were due to be reinstated when the new staff commenced in post.

**Working with colleagues and other services**

The practice worked with other service providers to meet people's needs and manage patients with complex needs. Results of blood and X ray results from the local hospital were received electronically. Requests for tests were also made via an electronic referral system. A system was in place to ensure results were allocated to the requesting GP. Results were reviewed on a daily basis and there was a cover system to ensure results were reviewed when a GP was absent from the practice.

Other communication with hospitals was undertaken by post or fax. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

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 a

Good

# Are services effective?

## (for example, treatment is effective)

level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings once a month to discuss the needs of patients with complex health needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented. The health visitor was also involved at meetings to discuss child health. Staff we spoke with felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Some additional services were provided at the practice. For example, a memory clinic was held once a week. This enabled the GPs to communicate directly with other professionals to support patient care.

### Information sharing

The practice used electronic and manual systems to communicate with other providers. For example, there was a system, called patient notes, with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice used a combination of communication systems to make referrals to local hospitals through the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they wished to be seen in and to book their own outpatient appointments in discussion with their chosen hospital). There was a tracking system in place to follow up on urgent referrals for patients who needed to be seen within two weeks at the hospital. There was a daily collection of referral letters and fax communication with some departments was used to ensure letters were received in a timely manner. Cover arrangements were in place to ensure referrals were processed when the secretary was on holiday.

The practice had a system in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved on the electronic patient record for future reference.

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Medical data (for example, record of allergies) would be securely shared, for those patients who had consented, with other providers of health care to support delivery of emergency care. For example, when a patient attended a hospital accident and emergency department.

### 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. The GPs, Nurse and HCA we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were given examples of when staff had decided to suspend treatment in the patient's best interest until an informed decision to take up the treatment had been reached. The practice training records showed us that staff had received training in applying the principles of the MCA.

Patients with a learning disability 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). 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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. The GP who undertook minor surgery told us that they gave patients written information relevant to the surgical procedure undertaken. We discussed recent best practice guidance for obtaining written consent for minor surgical procedures and insertion of contraceptive coils. The practice were reconsidering the need to obtain written consent following these discussions.

### Health promotion and prevention

Good

# Are services effective?

## (for example, treatment is effective)

The practice supported initiatives to improve health. A member of the patient participation group (PPG) had commenced a weight loss class. The practice provided a room and supporting clinical back up for this group which met once a week.

A range of health promotion material was available in the form of advice leaflets. These included information on memory loss, smoking cessation and sensible drinking. However, the leaflet rack holding this material was not prominently positioned and patients seeking health promotion information, or information about local support groups, may not have realised this was available. GPs and nurses also had access to online health promotion information and copies of leaflets on a range of health promotion subjects. Some of the patients we spoke with told us they had received advice on both the benefits of losing weight and stopping smoking.

The practice and the PPG took an active role in health promotion in the local community. For example within carers forums, the local live well project and prevention matters project.

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 childhood immunisations met the national targets and there was a system in place to follow up those that did not attend. The practice's performance for cervical smear uptake was above the 80% national target. There was a procedure in place to follow up women who did not attend for this test. The practice took part in the national screening campaigns for chlamydia, mammography and bowel cancer.

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, a satisfaction survey undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The national survey results showed 92% of 104 patients who answered the question about nurses being good at listening rated the nurses as good or very good. Eighty four per cent of patients rated the GPs as good or very good in response to the same question. The responses to the question whether GPs and nurses treated the patient with care and concern reflected the point in time when the survey was taken. That was during a period when a partner was not working and locums were employed. Ninety six per cent rated nurses as good or very good for this measure (17 patients said this question did not apply to them) and 72% rated the GPs as good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring service and that GPs and nurses efficient and helpful. The last data from the national survey showed patients were concerned about the level of privacy offered at the reception desk. We saw that the practice had introduced a system to allow only one patient at a time to approach the reception desk. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

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

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed related to a survey undertaken when the practice was in a period of staff change. The GPs we spoke with were aware that the levels of satisfaction at that time were below the majority of other practices in the CCG. These included the responses to the questions relating to the GPs and nurses involving patients in decisions about their treatment. However, 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 positive and aligned with these views.

We noted that the national patient survey had been taken at a time when locum GPs were employed at the practice. Discussions we held with GPs and nurses showed us that they were aware of the patient feedback from the national survey and were paying close attention to the matters where the results were lower than the rest of the CCG. For example, we saw that GPs undertook home visits for patients requiring a written care plan to ensure the patient was involved in decisions about their care.

The national patient survey results in respect of patients having trust in their GP and the nurse they saw were aligned with the rest of the CCG practices. A survey undertaken by the practice in August 2014 showed that overall patient satisfaction had increased by 20%.

**Patient/carer support to cope emotionally with care and treatment**

The responses on comment cards we reviewed told us that staff offered compassionate support to patients when needed. We heard that patients could be accompanied by a relative during a consultation if they wished and that chaperones were available to support patients during examinations and treatment. We saw parents accompanying children to their consultation. Patients we

Good

# Are services caring?

spoke with were positive about the compassionate support they received from the GPs. There were further examples of family members being given bereavement support after the death of a relative received via the comment cards.

There were some leaflets in leaflet rack near reception and information on the patient website offering advice to patients on how to access a number of support groups and organisations. The practice held a register of patients who were also carers and meetings for carers were held at the practice. When carers could not attend the practice they were offered home visits.

There was evidence that patients who required care plans to assist them in avoiding admission to hospital were visited at their home if they found it difficult to attend the practice. This enabled this group of patients to contribute to the formulation of their care plans without the worry of having to get to the practice.

Some of the comments received via the comment cards informed us that both GPs and nurses provided patients with advice and explanations of treatment that helped patients both understand and come to terms with the tests or treatment they were intending to access.

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 practice was actively engaged with the Aylesbury Vale Clinical Commissioning Group (CCG) and took active part with them and other practices to discuss local needs and service improvements that needed to be prioritised. An audit showed us the practice had engaged in the review of attendances at the A&E department. The results evidenced that GPs critically reviewed whether attendance at A&E was appropriate. One of the GPs was a member of the CCG board and brought issues back to the practice for discussion with colleagues. The practice ensured that patients who had been discharged from hospital were followed up and patients who were included in the admission avoidance group were contacted within three days of discharge if they were admitted to hospital.

A range of clinics and services were offered to patients, which included family planning, antenatal, children's immunisation and minor illness. The practice ran regular nurse specialist clinics for long-term conditions (these clinics were held by locum nurses at the time of the inspection). The clinics included diabetes and asthma clinics. Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with long term condition on practice register and organised recall programmes accordingly.

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, providing high back chairs in the waiting room to assist patients who had difficulty getting into and out of low chairs.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups of patients in the planning of its services. A significant number of elderly patients were registered with the practice and the practice had patients' registered from rural communities. It was recognised that this group of patients often found it difficult to get to the practice for appointments. A flexible appointment system was in place to enable patients who used a local voluntary transport service to use this to get to the practice. Appointments were either moved within standard clinic times or added to clinics to fit in with the times the voluntary transport could get the patient to and from the practice.

The practice had very few patients registered whose first language was not English. When these patients attended for an appointment they brought a family member or friend to assist with translation. Staff we spoke with told us that they had not encountered problems with translation for this small group of patients and if they did they would contact the local hospital to access translation services. The practice was fitted with an induction loop system to assist patients who used hearing aids. One of the GPs was fluent in British Sign Language (BSL) and was able to support patients who were profoundly deaf and used this form of communication. The print on any written information could be enlarged to assist patients with a visual impairment.

A small number of patients from a local traveling community were registered with the practice. The practice recognised that some of these patients had literacy difficulties and verbal communication was used to support these patients. Patients we spoke with from this community told us they found no problems accessing the services at the practice and had received good treatment and support.

The consulting and treatment rooms were all located on the ground floor and there were toilet facilities for patients with a physical disability. We found all corridors leading to consulting and treatment rooms were wide enough to accommodate both wheelchairs and mobility scooters and gave sufficient room for both to be able to turn. 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. We saw that the practice had installed replacement automated entrance doors that facilitated access for patients with a physical disability. Although the previous entrance doors were automated the practice had responded to patient comments that they were not always 'user friendly'.

**Access to the service**

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Appointments were available from 8am to 6pm on weekdays. The practice was open from 8am until 6.30pm but closed for one hour during the lunch period. Emergency phone access was available during the lunch time closure and the duty GP was on call to deal with emergencies during this time. A mix of urgent on the day appointments, telephone consultations and book in advance appointments were available. When on the day face to face urgent appointments had been taken patients were given telephone consultation appointments to enable the GPs to support the patient in reaching a decision on whether an urgent appointment was needed. We saw minutes of a patient participation group (PPG) meeting which recorded positive feedback from patients about the availability of consultations.

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. The practice manager, GPs and the PPG members we spoke with also told us that the current practice appointment system had been publicised through patient newsletters and the local parish magazine. 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 call. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on the day they were requested. Home visits could be requested before 11am each day and when calls came in after this time the request was responded to by the duty GP. A number of older patients and those living in rural communities relied on a local voluntary transport service to bring them to and from the practice. The practice operated a flexible appointment system to accommodate these patients and fit in with the times the voluntary transport service could get them to and from their appointments.

Patients had not been happy with the appointment systems in the past. We heard from the PPG members we spoke with that some comments relating to difficulties in obtaining of appointments continued to be received. However, patient feedback showed us patients were able to either see a GP or receive a telephone consultation on the same day of contacting the practice. We heard from both the GPs and the PPG members that the practice was responsive to comments and feedback relating to difficulties in obtaining appointments. The appointments system had been reviewed and adjusted four times in three years. The last change to the system had taken place in spring 2014 and continued to be subject to evaluation.

The practice's extended opening hours on alternate Saturdays between 8am and 12noon were particularly useful to patients with work commitments. Both GPs and nurses held clinics during the Saturday morning extended hours. We heard how parents who worked found it helpful to be able to bring children for immunisations on a Saturday morning.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for ensuring all complaints were dealt with in accordance with the practice policy.

Information was available to help patients understand the complaints system. We asked some staff how they would support a patient wishing to make a complaint. They were able to tell us about the complaints procedure and how they would try to seek a prompt resolution for the patient by referring them to the practice manager in the first instance. We asked for a copy of the form which patients could use to lodge a complaint. Initially we were given the wrong form. We discussed this with the practice manager who took immediate action to ensure staff held the correct form to assist patients. The complaints procedure was detailed on the practice website and in the patient information leaflet. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the comments submitted to the national NHS Choices website relevant to the practice and noted that all comments posted in 2014 had been responded to by either the practice manager or a GP. The practice was alert to sources of feedback and complaint and took action where necessary. For example, the practice had liaised with the local pharmacist to resolve delays in the issue of prescriptions. The practice was undertaking an ongoing survey. Patients were able to complete the 'friends and

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

family' questionnaire This survey gauged the level of satisfaction with the overall service by asking patients how likely they were to recommend the service to their friends and family.

We looked at the complaints summary for the last full year of 2013 into 2104. This showed the practice dealt with 24 complaints. We saw that all had been dealt with in accordance with the practice complaints procedure. The complaints had been acknowledged, investigated and responded to in a timely manner. All had been responded to in full within 20 working days. The practice reviewed complaints annually. Learning from individual complaints was disseminated to staff via their line managers.

# 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 vision focussed on care. The stated vision included caring for patients, caring for the staff team and caring for other health care professionals and volunteers involved in the care and treatment of patients. The GPs and staff we spoke with demonstrated a clear commitment to caring for patients. The majority of the 27 comment cards we reviewed referred to the caring and supportive attitude of staff.

GPs and management showed commitment to working with others to develop services for patients. We heard how one GP was working with the CCG on research and planning for the introduction of a specialist team to support patients at risk of emergency admission to hospital and patients discharged from hospital that required extra support and advice.

There was evidence of the practice bringing services to the local population. GPs had recognised that the rural location coupled with an ageing registered population made it difficult to attend hospital departments. For example, a consultant and nurse specialising in supporting patients with dementia attended the practice once a week.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff in either a manual file or on the practice computer system. Key policies and procedures were also contained in the staff handbook. We looked at nine of these policies and procedures. All of the policies we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt 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 it was performing in line with national standards. We saw that QOF data was discussed at team meetings. When actions were required to achieve QOF standards these were noted and agreed to maintain or improve outcomes. There was evidence that the practice paid close attention to QOF performance. When an error occurred which resulted in monitoring results not being recorded action was taken to demonstrate the patients concerned had been supported.

The practice took part in local peer review of their prescribing performance. We looked at the report from the last peer review, which showed that the practice had achieved most of the targets for quality and improvement in prescribing.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, annual audit of control of infection and of minor surgery were undertaken.

**Leadership, openness and transparency**

Staff we spoke with were very positive about the open management style of the GPs and practice manager. All of the staff we spoke with told us they would feel confident to speak with the manager or any of the GPs if they had concerns or ideas on how to improve services for patients. There was evidence of a strong team spirit and a range of team meetings were held regularly, usually once a month for the administration and nursing teams. We heard how all staff had worked together to maintain patient services when the practice had been subject to a flood during the August Bank Holiday. We also noted that the practice took the opportunity offered by CCG training days to meet as a whole team. These meetings covered a range of day to day issues in addition to training topics.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and recruitment policy. All the policies we reviewed were dated and these dates showed us they had been reviewed in the last year. There was a staff handbook available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find the policies and a copy of the handbook if required.

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

The practice had gathered feedback from patients through surveys carried out up to August 2014, meetings with the patient participation group (PPG), complaints and

# Are services well-led?

Good

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

meetings with local councillors. We looked at the action plan from the 2013 patient survey which was published in March 2014. This told us that the practice was introducing a revised appointments system and updating the practice telephone system. We saw that these actions had been taken. The practice manager and GPs were keeping the appointment system under review as it had been in place for less than a year.

The practice had an active patient participation group (PPG) which was well supported. The PPG meetings were regularly attended by between 20 and 40 patients. We met with three members of the group they told us about their input to wider patient forums within the CCG and nationally. They also told us that they continued to receive comments from patients relating to access to appointments. They were aware that the practice had made three adjustments to the appointment system in the last two years. We were told that the introduction of appointment triage by GPs had been as a result of PPG feedback. The PPG were supporting the practice in carrying out the friends and family test survey (the friends and family test offers all patients the opportunity to rate whether they would recommend the service to their friends and family if they needed similar care or treatment).

Staff told us they had opportunities to give management and GPs feedback through their team meetings and line managers. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff valued the opportunity to meet as a full practice team during CCG training afternoons and they told us they felt involved and engaged in the practice to improve outcomes for both staff and 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 development through training and review. The staff we spoke with all told us they received annual appraisal. They told us this included reviewing their achievements, looking at objectives for the year ahead and identifying their training needs. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. The practice manager held a central record of training that had been completed. This record also identified when training updates were due. The practice had signed up to an online training resource and all staff held a training account.

The practice was a GP training practice. We heard that the GP trainers supported GPs in training who required extra help in addition to the day to day training of prospective GPs allocated to the practice. The practice had been approved for training for a number of years and two of the partner GPs held diploma's in medical teaching.

The practice had completed seventeen reviews of significant events in 2014. These had been shared with relevant staff via team meetings or at whole practice meetings. We saw the practice acted to support and improve patient care when other providers were involved. For example, reviewing diagnoses made by hospital doctors.