Plas Ffynnon 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 5 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice had recognised that patients were experiencing difficulties accessing appointments, particularly pre-bookable appointments. The appointment system had been amended to provide more on the day appointments and increased telephone triage by practice nurses.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- Staff were all clear about their own roles and responsibilities, and felt valued, well supported and knew who to go to in the practice with any concerns.

We saw several areas of outstanding practice including:

- The practice website had the option of audio, translation into other languages and the font size could be increased.

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

Summary of findings

The provider should:

- Ensure a protocol is in place detailing which patients' medicines can be reviewed by the senior dispenser.
- Ensure a system is in place for tracking prescription pads through the practice.
- Obtain robust recruitment histories for all new staff.

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. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Data showed patient outcomes were above average for the locality. People'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 all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice, and confirmed that they were usually offered a same day appointment when they telephoned, and could also book appointments in advance. The practice offered extended hours every Saturday morning. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a strong and visible leadership which was well supported by the staff team. There was a clear leadership structure and staff felt well 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 practice had an active Patient Participation Group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had been notified of their named GP. The practice had identified vulnerable older patients and had developed individual care plans to support their care needs. These care plans were shared with the out of hour's provider, with the patient's permission. Influenza and shingles vaccinations were offered to older patients according to national guidance. Home visits for vaccinations were arranged for older patients who were housebound.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. We found that the nursing staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as diabetes and asthma. The nursing staff were supported by lead GPs for each long term condition. The practice maintained registers of patients with long term conditions. Individual care plans had been developed to support their care needs. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks at a time suitable to them. Staff were proactive in following up patients who did not make appointments for their reviews.

Families, children and young people

Good

The practice is rated as good or the population group of families, children and young people. Staff were knowledgeable about how to safeguard children from the risk of abuse. There were systems in place to identify children who were at risk. There was a good working relationship with the health visitor attached to the practice. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Immunisation rates were in line with or above the local Clinical Commissioning Group average for all standard childhood immunisations. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those who have recently retired and

students). The practice offered a range of appointments which included on the day and pre-bookable appointments, as well as telephone consultations. The practice offered extended hours on a Saturday morning. The practice was pro-active in offering on line services as well as a full range of health promotion and screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 74 years old a health check with the practice nurse. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

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. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence or part of the travelling community to register with the practice. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice told us they were supported by the community substance misuse team in the care of patients with substance misuse.

Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group experiencing poor mental health (including people with dementia). The practice held registers of patients with mental health needs, including depression and dementia. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place. Counselling services held sessions at the practice each week and patients could be referred by their GP or make a self-referral. This enabled patients to receive counselling and treatment in surroundings that were familiar to them.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection. Patients were very satisfied with the service they received at the practice. They told us they could get an appointment at a time that suited them, including same day appointments. They told us they had confidence in the staff and they were always treated with dignity and respect.

We reviewed the 14 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that almost all comments were extremely positive. Patients said they felt the practice offered a good service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and helpful. Patients commented that the GPs in particular gave them time and listened to what they had to say. One comment card was less positive and related to the recently introduced nurse triage system and the advice given.

We looked at the national GP Patient Survey published in December 2013. The survey found that 91.7% of patients described their overall experience of Plas Ffynnon Medical Centre as good or very good, which was in the middle range. In addition, 85.5% of patients would recommend the practice to someone new to the area, which was also within the middle range.

Areas for improvement

Action the service SHOULD take to improve

Ensure a protocol is in place detailing which patients' medicines can be reviewed by the senior dispenser.

Ensure a system is in place for tracking prescription pads through the practice.

Obtain robust recruitment histories for all new staff.

Outstanding practice

The practice website had the option of audio, translation into other languages and the font size could be increased.

Plas Ffynnon Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor.

Background to Plas Ffynnon Medical Centre

Plas Ffynnon Medical Centre is located in Oswestry and provides primary medical services to patients who live in Oswestry and the surrounding villages.

The practice has six permanent GPs (four male and two female) and one Registrar, a practice manager, four practice nurses, five healthcare assistants, a phlebotomist, reception and administrative staff. There are 9068 patients registered with the practice. The practice is open from 8.15am to 6pm every weekday except Thursday, when the practice closes at 5pm. The practice offers extended hours on Saturday mornings from 8.30 to 10.45am. The practice treats patients of all ages and provides a range of medical services. Plas Ffynnon Medical Centre has a higher percentage of its practice population in the 65 and over age group than the England average.

The practice provides a number of clinics for example asthma, diabetes and heart disease. It offers child immunisations, minor surgery, telehealth dermatology and travel health. The practice also provides a minor injury and phlebotomy service.

Plas Ffynnon Medical Centre has a General Medical Services contract.

Plas Ffynnon Medical Centre is a postgraduate training practice for GP Registrars. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

Plas Ffynnon Medical Centre is an accredited training practice for nurses working towards a degree in practice nursing.

Plas Ffynnon Medical Centre does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

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

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

Detailed findings

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team.

We carried out an announced visit on 5 November 2014. During our inspection we spoke with three GPs, two practice nurses (one training to be a nurse practitioner), one health care assistant, the practice manager, dispensary staff and two reception/administration staff. We spoke with five patients who used the service about their experiences of the care they received. We reviewed 16 patient comment cards sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group, and a manager from a local nursing home.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. Significant events were a standing item on the weekly partners meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. 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 they felt encouraged to do so.

Staff used paper incident forms and sent completed forms to the practice manager. They showed us the system she used to manage and monitor incidents. We tracked incidents recorded between July and October 2014 and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example we saw that a patient had missed an appointment for a contraceptive implant. As a consequence, patients receiving contraceptive implants had this information highlighted on their notes and a recall system had been put in place, inviting patients to attend appointments as required.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with described the action they would take for alerts that were relevant to the care they were responsible for. They also told us alerts were actioned by specific staff, for example one health care assistant was responsible for checking equipment, to ensure that action had been taken where required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the majority of staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in and out of working hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children who could demonstrate they had the necessary training to enable them to fulfil this role. This role was supported by the practice manager. Staff told us they would speak with their immediate line manager if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans and those patients who were also carers.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The nurses acted as chaperones when requested by the GP. Although not all staff had received formal training, they understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

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

GPs were appropriately using the required codes on their electronic case management system to ensure that patients requiring end of life care were clearly flagged and care plans developed and reviewed. Records demonstrated good relationships with partner agencies, such as the community and hospice nurses.

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. The practice did not have any alternative arrangements for storage of vaccines if the electricity supply was interrupted. The practice had validated cool boxes which could be used for transporting the vaccines.

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

We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. One of the GP partners had the role for overseeing the quality of dispensing of medicines. Dispensing staff at the practice were aware prescriptions had to be signed before being dispensed. The practice had introduced a system whereby the senior dispenser was able to carry out medicine reviews. However, a protocol was not in place detailing which patients' medicines could be reviewed by the senior dispenser.

Blank prescription forms were handled in accordance with national guidance. Although they were kept securely at all times, they could not be tracked through the practice as a log of the numbers was not maintained.

There was a system in place for recording and checking the medication held in the GP bags. Dispensary staff were responsible for carrying out these checks. Records demonstrated these checked had been carried out and medicines were within their expiry date and suitable for use.

Cleanliness & Infection Control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy. We saw that the practice was clean and orderly. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received training about infection control specific to their role. The infection control lead told us they were part the infection control working group with the Clinical Commissioning Group, and attended quarterly meetings. Information was disseminated to clinical staff via team meetings and infection control was a rolling agenda item.

An infection control audit completed by the local NHS trust in January 2014 had identified a small number of issues that required addressing. As a consequence, a number of

floor coverings had been replaced; the work of the contract cleaners was audited, and daily and weekly cleaning schedules for clinical staff had been introduced in clinical rooms.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff confirmed they used single use equipment for most procedures, such as tourniquets used when taking blood from patients. They also told us that if individual staff used their own fabric tourniquet, they were responsible making sure it was laundered.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received the relevant immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. One member of staff described a recent incident which demonstrated that this policy had been adhered to.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, thermometers, medical scales and blood pressure monitors.

Staffing & Recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw an up to date recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. We looked at four staff files. We saw that almost all of the appropriate checks had been carried out. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, we noted that employment histories were not always complete and did not include months and years staff had worked in previous jobs. This made it difficult to identify any short gaps in employment.

The practice manager told us that the staffing structure was under review, following the unsuccessful introduction of operational leads for each department. Following a strategy meeting, there were plans to appointment a deputy practice manager and additional reception / administration staff. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager told us the appointment of the additional staff would provide additional resilience to cover holidays and sickness. 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.

Monitoring Safety & 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 weekly fire alarm checks, medicines management, and dealing with emergencies and equipment. The practice also had a health and safety policy. Staff told us they could access the policies and procedures on the computer and paper copies were also available.

Identified risks were included on a risk log. The practice manager told us that the risk assessments and policies were reviewed on an annual basis. Any changes or updates were discussed at the risk assessment meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: the practice had identified patients who were at high risk of admission, as well as those with long term conditions, dementia, mental health needs and learning disabilities. Individual care plans had been developed for each patient with the intention of reducing their unplanned admissions to hospital.

Good

Are services safe?

A member of reception staff described the action they had taken when patients became unwell whilst in the waiting room. They told us about a mother and baby who arrived on the wrong day for an appointment. Whilst rebooking the appointment they observed that the baby looked unwell and immediately notified the GP. The baby was seen by the GP and subsequently referred to the local hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We saw an example of when staff had followed basic life support procedures when a patient collapsed in the waiting room.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, staff did not record when they carried out these checks. 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 rated and mitigating actions recorded to reduce and manage the risk. The document contained relevant contact details for staff to refer to. Staff described an occasion when the plan had been put into action and the practice temporarily moved to another practice within the locality due to a power failure.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the majority of staff were up to date with fire training and that they practised regular fire drills.

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. We saw minutes of primary health care team meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, changes to the guidelines on atrial fibrillation (heart condition) and the use of oral anticoagulants (blood thinning medication) were discussed in July 2014, and consideration given to identifying those patients with the condition to ensure they were on the correct medication. 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.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice had identified patients with long term conditions and had developed individual care plans to support patients to ensure their care needs were met and avoid unnecessary hospital admissions. These patients were provided with a dedicated telephone number at the practice, so they had could access appointments when required.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertaken regular clinical audit. The QOF rewards practices for providing quality care and helps to fund further improvements. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 98.6 QOF points, which is higher than the national average. Each GP partner took a lead role for monitoring QOF targets, for example: diabetes, cancer and asthma. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us three clinical audits undertaken in the last three years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example: the practice carried out an audit of the use of Epipens by patients. Epipens are used when a person suffers a severe allergic reaction. The purpose of the audit was first to check Epipens were being used appropriately by patients. The audit also looked at whether patients were being advised to check that their Epipen was in date. The results showed an improvement in the rate of prescriptions of Epipen being appropriate from 92% to 95%. The rate of patients having an in-date prescription remained the same at 92%. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their contract. However, the last audit available and seen on the day of inspection was dated March 2013.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses such as annual basic life support and safeguarding vulnerable adults and children. 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, for example the practice was supporting the nurse manager through their nurse practitioner training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

The practice nurses and health care assistants had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example seeing patients with long term condition such as asthma and diabetes, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received either electronically or as a paper copy. Each GP reviewed information from other services about their patients. Each GP was responsible for the action required and would either record the action or arrange for the patient to be contacted and seen as clinically necessary. For example, a patient whose blood result showed a low potassium level was contacted and admitted to hospital. Systems were in place to ensure that patient information was reviewed when GPs were on leave. One GP acted as a duty doctor each day, and dealt with any correspondence or results received. The practice used an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician or trainee. Required actions were recorded on the electronic system and passed on to the relevant person to action. For example, if results were normal, this was recorded so that reception staff could inform patients when they contacted the surgery.

The practice held multidisciplinary team meetings to discuss patients on the palliative care register. These meetings were attended by district nurses, palliative care nurses, the GPs, practice nurses and health care assistants. All patients identified as having end of life needs were discussed 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.

Staff told us that although the health visitors, school nurses and midwives did not attend the multidisciplinary meeting, they had good working relationships with them. One GP told us that they had contacted the health visitor after seeing a patient and the health visitor had visited the patient within a week of the request.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS 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 in the system for future reference.

The practice offered a Choose and Book option for patient referrals to specialists, and the GPs spoken with told us that the system worked well. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. The practice used a template to record the information required for an urgent suspected cancer referral. The referrals were processed by the secretaries and faxed through to a central point. The GPs told us they checked the outcome of the referrals and always ensured that patients with an urgent referral had been seen.

The majority of staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gather, used and shared.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and assessment of Gillick competency of children and young adults, and information around the Frasier guidelines. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. Clinical staff told us that patients

Are services effective?

(for example, treatment is effective)

had a choice about whether they wish to have a procedure carried out or not. They told us they took the time to fully explain procedures and checked the patient understood before proceeding.

The GPs spoken with told us they had received training on the Mental Capacity Act and assessing patients' mental capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Nursing staff told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment. Staff records indicated that not all clinical staff had received training on the Mental Capacity Act 2005.

We saw examples that supported the GPs had sought the patient's consent to certain decisions, for example, do not attempt resuscitation care plans. We saw that the appropriate paperwork had been completed, and discussed with the patient during a home visit. We also saw that when a patient had lost the capacity to make an informed decision, best interest decisions were made in consultation with others. For example, a patient was seen and their care discussed with another GP and then with the relatives.

Health Promotion & Prevention

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history. They were also invited to book an appointment with a member of the nursing team for a new patient health check. The practice also offered the NHS health checks to all patients aged 40 to 74.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, weight management (referral to group held at another practice) and smoking cessation. Patients who met certain criteria could also receive gym membership on prescription. We were also told that the practice carried out child immunisations and offered family planning advice and support. The practice nurse we spoke with told us that health promotion information was available for all patients. They told us that they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. A range of leaflets were available in the waiting room.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with or above the average for the local clinical commissioning group.

Flu vaccination was offered to all over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was slightly below the national average. The shingles vaccine was offered according to the national guidance for older people.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in providing additional help. For example, the practice kept a register of all patients with learning disabilities, mental health needs and dementia and each patient was offered an annual physical health check.

The Patient Participation Group (PPG) were also involved in supporting the practice to promote a healthy lifestyle. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The chairperson of the PPG told us members have supported the practice to promote attendance at flu clinics and helped out on the day. Previously they had organised a stand in the local market hall where they handed out packs promoting vaccinations from childhood through to old age. They have been involved in supporting the use of community automated external defibrillator (used to attempt to restart a person's heart in an emergency), and handing out health promotion leaflets and information about the local minor injuries unit at the local show.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 417 patients undertaken by the practice's patient participation group (PPG). PPGs are intended to be an effective way for patients and GP practices to work together to improve the service and to promote and improve quality of the care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'in the middle range' for patients who rated the practice as good or very good, with a percentage of 91.7%. The survey showed that 98% patients felt that the doctor was good at listening to them, which is above the Clinical Commissioning Group (CCG) area average. 95% of the patients who responded said the last GP they saw or spoke to was good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and the majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service, and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive and related to the recently introduced nurse triage system and the advice given. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place could not be overhead. The doors automatically locked and could only be opened with a key fob, with prevented anyone from walking during a consultation. We observed staff knocked on closed doors and waited to be invited in before entering.

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, which helped keep patient information private. There was a system in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We observed the senior receptionist manage a patient query in a dignified and respectful manner. The patient and family member asked to be seen in private, which was facilitated by the receptionist. The receptionist addressed their concerns, and organised an appointment with the GP. The outcome for the patient was positive as they were seen within 20 minutes of arriving at the practice. The receptionist also took the opportunity to obtain consent for sharing information with the family member at this time, to assist with communication.

Staff told us that the practice cares for patients whose circumstances may make them vulnerable. This included people from the travelling community, people with substance misuse and the occasional homeless person. Staff told us that these patients were supported to register as either permanent or temporary patients, as the practice had a policy to accept any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff told us about an occasion when a distressed patient had visited the practice asking to see a GP. The patient was not registered at the practice and did not have any identification with them. It was considered in the person's best interest for them to be seen straight away. This person was seen by a GP and arrangements made for them to move into a place of safety.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. One patient told us

Good

Are services caring?

the GPs fully explained everything and gave them the opportunity to ask questions. Patient comments on the comment cards we received were also positive and supported these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above the average compared to the Clinical Commissioning Group (CCG) area average. The results from the practice's own satisfaction survey showed that 91% of patients said they were sufficiently involved in making decisions about their care.

Staff told us that the population of the patients at the practice were mainly white, British people, with a very small number of ethnic minority patients registered with the practice. Staff told us patients whose first language wasn't English were usually accompanied by a family member or friend who would translate for them. However an interpreter could be arranged if it was inappropriate for a family member or friend to attend the consultation.

There were 36 patients registered at the practice and identified on the practice's learning difficulties register. Staff told us that annual health reviews were carried out for patients with learning difficulties and care plans developed following the review. The practice had identified 58 patients with mental health difficulties who required additional support. There was a system in place to ensure that patients with mental health difficulties received an annual health review. Reviews and care plans had also been completed for the patients on the dementia register. Staff told us that patients with long term conditions, such as diabetes or high blood pressure, were called for a review of their care and treatment annually. These patients were provided with extended appointments at a time that was convenient to them.

We spoke with the manager from a local care home that cared for patients with complex health needs. They told us staff were understanding of their needs but also treated them in the same way as any other patient when they visited the practice. They commented that the GPs were very knowledgeable about the people they cared for and always gave them time. They explained to us that the GPs took time to explain any results to the patients and their families. They told us the GPs advised them to ask families to contact the practice between specific times if they wished to discuss their relative's care and treatment.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 95% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 81% for nurses. These results for the GPs were above the CCG area average, although for the nurses it was below. These 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, patients described the care they received as excellent.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

The practice did not routinely contact families who had suffered a bereavement. Staff told us that each GP would decide if contact was required or bereavement counselling should be offered. However, all staff within the practice were notified about a patient's death.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider understood the different needs of the population it served and acted on these to design services. A phlebotomy (blood taking) service had been established at the practice so that patients did not have to travel to the local hospital. The practice had also introduced a 'one stop' system for patients with long term conditions. Patients would attend for one appointment, where all of the tests were completed and they saw other relevant professionals. For example, patients with diabetes would have their bloods and general observations taken, and also see the chiropodist. They would attend for their review appointment with the practice nurse.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. The practice was monitoring the risk of unplanned admissions and had developed individual care plans for patients. We saw that longer appointments were available if required. Patients who required longer appointments were identified on the electronic system, and longer appointments were available on request.

One of the GP partners attended monthly local Clinical Commissioning Group meetings, and told us that these meetings provided effective two way communication. The practice also attended three monthly locality meetings, which provided the GPs with an opportunity to discuss any issues, for example: specific cases and accident and emergency admission rates.

We spoke with the manager from a local care home that cared for patients with complex health needs. They told us they worked in partnership with the practice to meet the needs of the patients. The practice visited the care home every week to review patients who required a GP visit. Staff said that between the weekly visits, they could telephone the practice for guidance, or to request a visit. They told us patients with long term conditions, for example diabetes, were invited to the practice for their reviews, and if required, transport would be arranged. The practice also cared for patients in other care homes, and these patients were seen by the GPs on request.

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). We spoke with a representative of the PPG who explained their role and how they worked with the practice. We saw that action plan developed in 2013 following the patient survey had been implemented. The practice had appointed additional GP partners, reducing the use of locum GPs; ensured a receptionist was on the front desk at all times and amended the complaints procedure, so that the Practice Manager dealt with any complaints received. The patient survey had been repeated in 2014, and a further action plan developed.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. The practice supported people from vulnerable groups to register temporarily so they could access medical services. The practice had a policy to accept any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member or friend who would translate for them. Staff told us they could arrange for an interpreter if required. We saw that the website could be translated into different languages. An audio facility was also available, enabling patients to listen to the content of the website (only in English), and the size of the writing could also be enlarged. We did not see any leaflets in different languages for patients, although information could be translated via the website. There were two female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice provided equality and diversity training through e-learning. Training records showed that some but not all staff had completed this training.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There was a lift to the first floor. There was a hearing loop system available for patients with a hearing impairment. We saw that the

Good

Are services responsive to people's needs?

(for example, to feedback?)

waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone or in person to ensure they were able to access the practice at times and in ways that were convenient to them.

The practice opened from 8.15am to 6pm every weekday except Thursday, when the practice closed at 5pm. The dispensary opened from 8.30am to 6pm every weekday except Thursday, when it closed at 5pm. All clinics were available by appointment and patients could book these on the telephone, online or at the reception desk at the practice. Extended hours were available on Saturday mornings from 8.30am to 10.45am. These appointments were particularly useful to patients with work commitments.

As a result of patient comments and the length of time patients waited for pre bookable appointments, the practice reviewed and amended the appointment system in November 2013. The changes included a reduction in the amount of pre bookable appointments each day, resulting in an increase in the availability of same day appointments. The representative from the patient participation group (PPG) told us they had supported the practice, by being available in the waiting room when the new system had been introduced, to explain to patients how the new system worked. Staff told us that the changes to the appointment system had decreased the amount of patients that 'did not attend' their appointments.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out of hour's service. If patients called the practice when it was closed, their call was diverted to the out of hour's service.

Patients were satisfied with the appointments system. They confirmed that they were usually offered a same day appointment when they telephoned, and could also book appointments in advance.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Patients were made aware of how to complain through the practice booklet and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions were taken to resolve the complaint as far as possible. The practice had received seven complaints from April to October 2014. We saw that these had been handled satisfactorily and discussed at the partners meeting and any other meeting (if appropriate).

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, safe and effective medical care and promote good outcomes for people. The practice's vision statement was 'The doctors, nurses and all the staff are committed to delivering high quality cost effective integrated care responding to the needs of our patients'. The registered manager told us that the protected learning sessions attended by all staff were used to promote the vision and values of the practice.

The practice was proactive in its approach to develop the services they provided. The nurse manager told us the appointment system had been changed following an audit of availability of appointments. As a consequence the nurse triage system had been extended and additional phlebotomy (taking blood) services had been introduced. We were told by the practice manager and registered manager that the practice was looking to improve patient access by supporting the nurse manager's training to become a nurse practitioner.

Governance Arrangements

All staff had access to policies, procedures and clinical guidelines either through paper copies which were stored in files or through information available on the practice's intranet. Staff were aware of the access arrangements on the computer system. The practice manager told us that all policies were reviewed annually and those seen were up to date. Staff told us they were able to access policies when they needed information or were guided to read the latest information. We saw there was a system in place to ensure staff had read any revised policies when there were any changes or updates.

The practice held a range of meetings, which included partner meetings, primary health care team meetings and Quality and Outcomes Framework (QOF) meetings. All practice staff meetings and administration staff meetings were also held. We looked at minutes from a number of the different types of meetings and saw that performance, quality and risks had been discussed.

The nursing staff told us about a local peer review system they took part in with neighbouring GP practices. They said they used these meetings as an opportunity to discuss any new guidelines, such as the recent changes to practice such as how to obtain samples, and to share ideas around ways of working and best practice.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.

The practice also regularly carried out clinical audits internally, for example correct coding of deep vein thrombosis (blood clots in leg veins), appropriate prescribing of medication for severe allergic reactions (Epipens) and referrals for removal of cervical polyps. Findings were shared with staff and actions and recommendations were recorded.

We saw that the practice worked to the identification of risks and risk management. The practice manager showed us their risk log which addressed a wide range of potential issues, such as Control of Substances Hazardous to Health (COSHH), fire safety, buildings and prevention of the legionella virus. Risk assessments were in place and updated at least annually. Regular risk assessment meetings were also held.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example one of the GP partners was the lead for safeguarding and had the role of Caldicott guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. The nurse manager took on the lead role for infection control and attended meetings with the local Clinical Commissioning Group. We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that they felt the practice was well led. We saw that there was strong leadership within the practice and

Are services well-led?

Good

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

the senior management team were visible and accessible. Nursing staff told us that the GPs took their lead roles seriously and supported nursing staff with clinics for patients with long term conditions.

Staff told us that the GPs and practice manager were very supportive. Staff spoken with told us that management were open to ideas and listened to suggestions made by staff regarding improvements. One example of this was the changes to the appointment system.

The registered manager and practice manager told us how they supported staff who had been away from work for a period of time. They described how they carried out a supportive back to work interview, arranged for occupational health assessments if required, planned a phased return to work, purchased any specialist equipment identified as being required, and altered the environment to meet the needs of the individual member of staff.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints. The 2013 / 2014 patient survey focused on receptionists and appointments, consultations, keeping healthy and complaints. The practice was working with the Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. An action plan had been developed and implemented. Actions included to improve the amount of time a receptionist was available at the desk, better communication with patients about booking appointments on line, and informing patients if there was a delay of over 20 minutes.

The practice had an active Patient Participation Group (PPG) as well as a virtual PPG group. The minutes of the meetings, survey results and action plan were available on the website and on the notice board in the waiting room.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). The PPG met 11 times a year. Two GPs shared the lead role for the PPG. The practice manager always attended the meetings, supported by a GP whenever possible. Results of patients' surveys and PPG comments were shared with patients through the practice website. We saw that the PPG had developed an action plan and the practice had worked with the PPG to carry out the issues within the action plan. The chair person for the PPG confirmed that they had a very good

working relationship with the practice and that the partners were open and honest and listened to what they said. They told us they had worked with the practice when the appointment system was changed. Members of the PPG were available in the waiting room to explain to patients how the new system worked.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that they received an annual appraisal and there was a policy in place to support this. Staff told us that the practice was very supportive of training and that they had protected learning time three times a year. Individual members of staff told that they were supported to develop their skills to extend their role, for example, wound care and ear syringing. The practice manager and the nursing team had been shortlisted for The General Practice Awards 2014. The practice also won The Practice of the Year 2014 award for reorganising the way it treats patients with chronic diseases. The practice introduced an innovative approach by creating special combined clinics for patients attending annual appointments for conditions such as diabetes, asthma, hypertension and coronary heart disease.

The practice was able to evidence through discussion with the GPs and practice manager and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that the outcome of complaints received and resolved had been discussed at the management meeting held on 15

Are services well-led?

Good

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

October 2014. We saw the practice significant events log for July 2014 until October 2014 which gave details of the incident, who was involved, action taken and lessons learned.

Two of the GP partners were responsible for the induction and overseeing of the GP registrar's training. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a GP registrar who told us there was strong leadership within the practice. There was a buddying system in place to support GP registrars that provided them with a named GP on a daily basis who they had direct access to for advice and support.

A number of the GP partners also held external and strategic roles with other health agencies. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. For example, one GP was involved with the Local Medical Committee and the out of hours service for the county, ShropDoc. Another GP was the Information Technology lead for the county. In addition the nurse manager was also part of the infection control working group at the local Clinical Commissioning Group.