Wigmore 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 carried out an announced comprehensive inspection at Wigmore Medical Centre on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services for the care of older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. 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 and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and 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 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 for patients about the services available was easy to understand and accessible. 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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 and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review, to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with the local district nursing team.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 90% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

All of the six patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed 31 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs.

The results from the National Patient Survey showed that 70% of patients said that their overall experience of the practice was good or very good and that 58% of patients would recommend the practice to someone new to the area.

The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) who they worked with to address concerns from patients. The last practice patient survey in December 2014 demonstrated that most respondents were satisfied with the practice overall.

Wigmore Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Wigmore Medical Centre

Wigmore Medical Centre is a purpose built premise and located in the residential area of Wigmore, Kent. The building has benefitted from subsequent extensions and refurbishments improving space and access. Wheelchair access to the building is through the front door. The inspection was undertaken at Wigmore Medical Centre. We did not visit the practice branch at Hempstead Medical Centre.

A team of three GP partners, (one male and two female), a practice nurse, a phlebotomist, a practice manager, receptionists, practice secretary and administrative staff provide care and treatment for approximately 4,629 patients. The practice is a training practice for GP trainees and Foundation year two (F2) doctors, however, there were no trainee doctors working at the practice at the time of our inspection. The practice has General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts.

The practice nurse carries out a wide range of nursing procedures at the practice. They are also specially trained in conducting a wide variety of well-person screening (including cervical smears), giving health promotional advice, monitoring some long term medical conditions and providing some contraceptive advice.

The practice is open Monday to Friday from 8am until 6pm. Appointments are available from 9.30am to 12.30pm Monday to Friday and 4pm to 7.30pm on a Monday and 4pm to 6pm on Thursdays and Fridays.

The practice has extended surgeries, with appointments available from 7.00am each Thursday morning and until 8pm each Monday evening. These appointments are targeted towards patients who have difficulty in attending throughout the normal day. Patients are advised to call NHS 111 when the practice is closed.

Why we carried out this inspection

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

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 May 2015. During our visit we spoke with three GPs, the practice manager, one practice nurse, two receptionists, the practice secretary, and six patients who used the service. We reviewed 31 comment cards, the practice's Family and Friends Test and NHS Choices website where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, one member of staff told us how they had responded when there was an on-site medical emergency. They told us they had reported and recorded the event. The member of staff described the learning from this event and how the incident had put their emergency treatment protocol into action and showed that it worked well.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 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 was a standing item on the practice meeting agenda and a dedicated meeting was held bi-weekly 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 incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked one incident and saw records were completed in a comprehensive and timely manner. There was evidence of action taken as a result for example, administration of a holiday vaccination (some of the vaccine spilled out of the patient's arm). Systems had been changed to prevent this from happening again. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manger to practice staff who signed a form to confirm that they had seen them. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in level three safeguarding and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Other health care professionals, who had contact with vulnerable children and adults, were involved in safeguarding the patients from the risk of harm and abuse as multidisciplinary safeguarding information held at the practice was appropriately being shared with the health visitor team and social worker for the area.

There was a system (Vision) to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues

when patients attended appointments; for example children subject to child protection plans or patients with a history of domestic violence. The system also identified if a patient was housebound and/or had a carer.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The GPs would act as a chaperone for each other and all nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Records showed that all reception staff who acted as a chaperone had undertaken a Disclosure and Barring Service (DBS) check and were awaiting confirmation.

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 procedures detailed in the medicines policy.

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

Records of practice meetings noted the actions taken in response to a review of prescribing data. For example, patterns of high risk antibiotic prescribing within the practice.

There were no controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) stored at the practice.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. Records showed that the nurse had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance, as these were tracked through the practice and kept securely at all times. Patients requiring repeat prescriptions were able to request them either in writing, on line or could put the repeat prescription paper request in the post box in reception. Repeat prescriptions could also be sent electronically to a nominated chemist of the patient's choice enabling them to collect a prescription when it was convenient to them. The practice did not routinely take prescription requests over the telephone.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Cleaning schedules were used and completed by staff to identify and monitor the cleaning activities undertaken on a daily, weekly and monthly basis.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. There were records to show that the lead had carried out an audit for the last year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. For example, an infection control audit had been carried out in April 2015 and 98% compliance achieved. There was an action plan to achieve 100% compliance by installing wall mounts for gloves and aprons. We spoke with the practice manager who told us that as a result of the audit they were in the process of completing the actions.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. Urine specimens were placed in a plastic bag by patients and handed to staff, the specimens were then disposed of in the sluice room. This was in line with the infection control policy.

Good

Are services safe?

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury of this nature. There were needle stick injury posters displayed in all of the clinical rooms near to the sharps boxes. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records confirmed that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. Records showed that legionella testing took place in May 2015 and the action plan noted that the practice was a low risk.

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. A schedule of testing was in use. Records showed evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometer. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was November 2014. Emergency equipment such as a defibrillator (electronic devices that apply an electric shock to restore the rhythm of an irregular heart) was available for use in a medical emergency. We saw that the equipment was checked weekly to ensure it was in working order and fit for purpose.

Equipment and the premises were appropriately checked to ensure they promoted staff, patient and visitors safety. Records demonstrated that training had been provided to staff in respect of fire safety awareness. The premises had an up-to-date fire risk assessment and regular fire safety checks were recorded. Records showed that the fire alarm system had been recently overhauled and a fire alarm test took place on the morning of our inspection. Staff we spoke with were aware of the evacuation policy and fire assembly points.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Informal induction was provided to new members of staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Records showed that there was always a floating receptionist and the practice secretary also worked across roles as secretary and receptionist. The practice did not use locum doctors as the three GPs provided cover for each other.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Good

Are services safe?

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Records showed that any risks were discussed at practice meetings and within team meetings. For example, the practice manager had discussed the lone working policy with the team and the necessity of keeping the door at the reception area closed for safety reasons.

Arrangements to deal with emergencies and major incidents

The practice had arrangements 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). There were systems to routinely check and record that it was fit for purpose. For example, the weekly check of the Automated External Defibrillator (AED) detailed that it was functional and that the gel pads in use were within their expiry date. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The notes of the practice's meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

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. There were processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was available and detailed how 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. There were arrangements for patients to continue to receive care during periods of the practice being closed due to such events. The practice had an agreement with their Hempstead branch to utilise a consultation room, in order for appointments to continue to be offered. 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 in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There were minutes of clinical team meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We spoke with clinical staff who told us that patients' needs and potential risks were assessed at initial consultations with the GPs. Individual clinical and treatment plans were agreed and recorded on the computerised system. Comprehensive and detailed patient records were kept on the electronic system and patients who had been assessed as 'at risk', for example, older patients, had care plans that were reviewed with the patient and their carer routinely. Every patient over 75 years of age had a named GP who was responsible for overseeing their care and treatment.

The GPs told us they lead in specialist clinical areas such as cancer care, family planning and child care and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with dementia which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. For example, housebound and long term condition patients.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients. For example patients with suspected cancers to ensure they were seen within two weeks. National data showed 35 patients (100%) were seen within the criteria. We saw that two week referrals were discussed at the monthly GP meetings. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice used the Referral Assessment Service (RAS) to refer patients to other services through choose and book system (a system that enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) and we saw an example of when this had been carried out. Minutes of practice meetings showed that choose and book referral letters had been discussed.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice actively promoted and supported the ethos and the requirements of the Equality Act 2010 and had an equal opportunities/anti-discrimination (service provision) policy. The practice provided the same treatment and services (including the ability to register with the practice) to any visitor irrespective of age, sex, marital status, pregnancy, race, ethnicity, disability, sexual orientation, medical condition, religion or belief.

Management, monitoring and improving outcomes for people

The practice kept registers that identified patients with specific conditions/diagnosis. For example, patients with dementia, learning disabilities, heart disease, diabetes and mental health conditions. The electronic records system contained indicators to alert clinical staff to specific patient needs and any follow-up actions required. For example, medicine and treatment reviews. The practice used an intelligence monitoring system HISbi to manage the

Good

Are services effective?

(for example, treatment is effective)

unplanned admissions. They also used the system to access the current list of inpatients. This was to avoid patients being sent letters if they were on their inpatient list.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of Simvastin (used to reduce the amount of cholesterol produced in the body). Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 534.6 of the total QOF target in 2014, which was in line with the national average of 559. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators were similar to the national average.
- The dementia diagnosis rate was comparable to the national average

For example, 89% of patients with asthma had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) dementia, depression, hypertension, rheumatoid arthritis. 100% of all patients on the dementia register received an annual review which included a medication review. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

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

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. For example, the practice kept a register of 13 patients with a learning disability. Records showed 100% had received a check up in the last 12 months. Structured annual reviews were also undertaken

Good

Are services effective?

(for example, treatment is effective)

for people with long term conditions diabetes, chronic obstructive pulmonary disease (COPD), heart failure. We were shown data that 93% of annual reviews for patients with COPD had been carried out in the last year.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. Benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, child immunisation, antibiotic prescribing and hospital referral rates.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix with two GPs having additional diplomas in obstetrics and gynaecology, child health and sexual and reproductive healthcare. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. 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. However, there were no trainee GPs at the practice on the day of our visit for the inspection team to speak with. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nurse had also completed specialist training in diabetes, asthma, family planning, travel vaccines, coronary heart disease, chronic obstructive pulmonary disease (a long-term respiratory disease) and updates in childhood immunisations.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Emergency hospital admission rates for the practice were relatively low at 11.12% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice was commissioned for the new enhanced service to provide care for over 75s and patients who may be at risk of unplanned admissions and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had employed a full-time nurse practitioner care co-ordinator who was the first point of contact for their housebound patients and older population.

The practice held monthly multidisciplinary team and palliative care meetings to discuss the needs of complex patients. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 69.5% of referrals last year

through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record Vision to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, where a patient could not give consent for a cervical smear test. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept a register of 13 patients with a learning disability and records showed that 13 care plans had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All GPs and nursing staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, cervical smear tests, 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.

Health promotion and prevention

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

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25. The practice also offered pre-booked appointments with their practice nurse for contraception advice for young people.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of 13 patients with a learning disability. Practice records showed 100% had received a check up in the last 12 months. The practice had also identified the smoking status of eligible patients and 100% have had smoking cessation advice. These groups were offered further support in line with their needs.

The practice had a dementia register of 32 people experiencing poor mental health and 100% had received

Good

Are services effective?

(for example, treatment is effective)

an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advanced care planning for patients with dementia. There was a dedicated trained GP who saw patients who had mental health issues and those on the mental health register were reviewed regularly. The practice undertook dementia screening, for patients over the age of 50 with a cardiovascular condition identified by a GP as being at risk of developing dementia. Screening was also offered to patients outside this group who were expressing a concern.

The practice's performance for the cervical screening programme was 83.64%, which was above the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named receptionist responsible for following up patients who did not attend screening.

Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG. For example, for breast screening 15 patients over the last year had the screening and for chlamydia screening 6% between January and December 2014 undertook the screening.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 70%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 93% to100% and five year olds from 87.5% to 95.8%. These were comparable to CCG averages.

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 2015, a survey of patients undertaken by the practice's patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of 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 'among the best' for patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with doctors and nurses. For example:

- 78% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 80% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 88% said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority were 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. We also spoke with six 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 consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 77% said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place, as staff meeting minutes showed this has been discussed.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 67% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and national average of 86%.
- 91% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the (CCG) average of 89% and the national average of 90%.
- 87% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the (CCG) average of 84% and the national average of 85%.

Good

Are services caring?

- 54% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 72% and national average of 81%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time compared to the (CCG) average of 92% national average of 92%.
- 95% said the last nurse they saw or spoke to was good at listening to them compared to the (CCG) average of 91% and the national average of 91%.

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.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 60% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 76% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, they were sent a card and the senior GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had well established links with the local area commissioners. Meetings took place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future. For example, enhanced community care to avoid unplanned hospital admissions.

The practice had a patient participation group (PPG). Terms of reference and the purpose of the group had been established and implemented. A survey had been developed to distribute to patients and there was analysis of the results of previous surveys which were completed by patients. PPG representatives told us they had looked at ways of recruiting new members from all of the patient populations groups and these had been successful. The practice had a website containing a section dedicated to the PPG, where recent surveys and the group's annual report could be accessed by patients and members of the public. 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, patients had commented that they wanted to access phlebotomy services at the practice. Action taken by the practice was to employ a phlebotomist for two sessions per week. Patients can access phlebotomy services within their own practice via a bookable appointment system which patients have told the practice they preferred. The service was publicised within the practice and on their website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, those with poor mental health or dementia and carers. The practice had access to online and telephone translation services. There was access to a hearing loop for people who had hearing impairment and, if required, the practice contacted a local service for signing for patients with a hearing problem.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice, therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open Monday to Friday from 8am until 6pm. Appointments are available from 9.30am to 12.30pm Monday to Friday and 4pm to 7.30pm on a Monday and 4pm to 6pm on Thursdays and Fridays.

The practice had extended surgeries, with appointments available from 7am each Thursday morning and until 8pm each Monday evening. These appointments were targeted towards patients who had difficulty in attending throughout the normal day. Patients were advised to call NHS 111 when the practice was closed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes by a named GP and to those patients who needed one. The homes had been given a mobile contact number to help avoid unplanned admissions to hospital.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 69% were satisfied with the practice's opening hours compared to the CCG average of 65% and national average of 75%.
- 69% described their experience of making an appointment as good compared to the CCG average of 64% and national average of 73%.
- 61% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.
- 73% said they could get through easily to the surgery by phone compared to the CCG average of 64% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment and was seen by a GP on the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice leaflet and website explained that there was a complaints procedure and a poster was displayed in the waiting area, to make sure that concerns were dealt with promptly. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at seven complaints received in the last 12 months and found they had all been reviewed and analysed in a timely way and that there was openness and transparency in dealing with the compliant.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and a theme had been identified. They found they had a number of verbal complaints regarding appointments in advance. The practice extended the senior GP's appointment books for up to six weeks if required for advance bookings and online appointments.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice. The practice vision and values included aiming to address and reduce health care inequalities, promote shared-decision making and deliver high quality cost-effective care and enhance their skills and flexibility to provide more complex care.

We spoke with two members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. They told us there was an open culture within the practice and that their opinions were listened to, respected and acted on.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 10 policies and procedures 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 the senior partner was the lead for safeguarding. We spoke with eight members of staff 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.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of management of urinary tract infections (UTI) in adult women. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire and staffing levels. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

We saw from minutes that team meetings were held every monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups. For example, five male and three female aged between 17 and 75, six of whom were British and two were Caribbean. The PPG had carried out an annual survey and met bi-monthly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with four members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice.

The practice had also 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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals 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 was a GP training practice for GP Registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine). There was a lead GP responsible for the induction and overseeing of the training for GP Registrars who were given a four month rotation.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, minutes of the May 2015 meeting showed that complaints and significant events over the past 12 months had been discussed including a prescribing error for a medicine in the form of a gel used to relieve the pain, discomfort and soreness of the mouth associated with mouth infections, ulcers and cold sores.