

Dr Hogg and Partners

Quality Report

Parklands Surgery
Wymington Road
Rushden
Northants
NN10 9EB
Tel: 01933 396000
Website: www.parklandssurgery.co.uk

Date of inspection visit: 10 October 2014
Date of publication: This is auto-populated when the report is published

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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	9
Areas for improvement	9
Outstanding practice	9

Detailed findings from this inspection

Detailed findings	12
-------------------	----

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr Hogg and Partners on 10 October 2014, as part of our new, comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

Our key findings were as follows:

- The practice was a, friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- The practice received high satisfaction rates for appointment availability.
- The clinical and administrative team had a good understanding of the needs of their patient

population. This was particularly the case in relation to those patients who were at most risk of poor health whose care was proactively managed through personalised care plans.

- Staff were multi-skilled and could carry out a variety of roles.
- People who cared for others were identified and their needs were also proactively managed by a carer's champion.

We saw one area of outstanding practice.

- The practice had taken steps to meet the need of patients with poor mental health by introducing phlebotomy services where travel to the local phlebotomy service might be stressful and anxiety provoking.

There was one area of practice where the provider needed to make improvements.

- The practice should take steps to ensure every staff member who might perform the role of chaperone has appropriate training.

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?

The practice was safe and is rated as good.

Staff understood and fulfilled their responsibilities to raise concerns, and report significant events or other incidents. 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 and there were effective arrangements to identify and respond to potential abuse. Medicines were managed safely and the practice was clean and hygienic. There were enough staff working at the practice and staff were recruited through processes designed to ensure patients were safe.

Good



Are services effective?

The practice is effective and is rated as good.

Data showed patient outcomes were at, or above average for the locality. Guidance and standards issued by the National Institute for Health and Care Excellence (NICE) and other bodies was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current standards and legislation. This included assessment of people's capacity, the promotion of good health and the prevention of ill-health.

Staff were properly qualified and trained appropriately for their roles and further training needs were identified and planned. The practice carried out appraisals of staff to ensure they were competent and had opportunities for development. Effective multidisciplinary working arrangements were in place.

Good



Are services caring?

The practice is caring and is rated as good.

Survey data showed patients rated the practice as good as or higher than others for most aspects of care except that the satisfaction rates for patients who said their doctors treated them with care and concern was slightly lower than average. This was at odds with patients views expressed during inspection and through comment cards where that experience was reported as wholly positive.

Good



Summary of findings

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Staff treated patients with kindness and respect ensuring confidentiality was maintained.

There was a chaperone service in place and patient's emotional needs in relation to their care and treatment were met through the practice's proactive care approach.

Are services responsive to people's needs?

The practice is responsive to people's needs and is rated as good.

The practice reviewed and understood the needs of their patient population particularly those who were at risk of unplanned hospital admissions. The practice ran a proactive care register for those who were most at risk and provided personalised care plans for this group of patients.

Patients reported good access to the practice with urgent appointments available the same day as well as late appointments for one day every week and alternate Saturdays.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is well-led and is rated as good.

The practice had a clear vision and philosophy of care. Staff were clear about the vision and their responsibilities in relation to it. There was a clear and visible leadership with an effective governance structure. Staff felt supported by management. The practice held daily coffee meetings after the morning's surgery to which all available staff were invited and encouraged all staff to contribute their views to the running of the practice.

Policies and procedures were in place to govern the practice's activity and there were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and this had been acted upon. The practice had an active patient forum. The practice had an open, transparent, learning culture.

Good



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

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people such as dementia and chronic lung conditions. The practice had a carer's champion and took steps to actively identify patients who cared for others in order to facilitate access to other services.

Patients aged 75 and over had their own allocated GP but could choose to see another GP if they wished. Flu vaccines for older people who had problems getting to the practice were administered in the community by the attached district nursing team. Doctors undertook home visits for patients who were unable to get to the practice.

The practice appropriately coordinated a multi-disciplinary team for the planning and delivery of palliative care for people approaching the end of life. The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including older people.

The practice maintained a proactive care programme for those patients who were most at risk and who had their own, personalised care plan.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

The review dates of patients with long term conditions such as heart disease, chronic lung disorders, stroke and diabetes were actively monitored to ensure their health needs were properly considered in line with national standards.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients.

All patients with long term health needs had a 'usual doctor' who retained oversight of their care.

Some patients with long term conditions that were considered to be most at risk had personalised care plans where their care was managed as part of the practice's proactive care register.

Good



Summary of findings

Families, children and young people

The practice is rated as good for the population group of families, children and young people.

Staff were effective in identifying potential child abuse and the computerised alert system identified individual patient's risk to enable clinicians to consider issues for consultations with children who were known to be at risk of harm.

There was a strong relationship with the Health Visiting service, which was based on-site, to manage and review risks to vulnerable children. There was a dedicated section on the practice web-site providing detailed information about family health. The community midwife also held ante-natal clinics at the practice.

The practice provided a full family planning service including the fitting of contraceptive devices. The practice also provided chlamydia screening.

Nationally reported data showed immunisation rates were higher than the national average for all standard childhood immunisations.

Good



Working age people (including those recently retired and students)

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

People who were looking after others were identified and proactively supported through a carer's assessment and a referral onwards to other services if required.

The practice currently did not offer the NHS adult health check for patients aged 40 to 70 years but offered these opportunistically during other health consultations. The health check programme for this group of patients was due to commence once the tendering process for this activity had been completed by the Clinical Commissioning Group (CCG).

Nationally reported data showed that the practice met the national targets for blood pressure monitoring for patients aged 40 to 70 years whilst the uptake for cervical screening was 86%.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. For example, recording of smoking status and providing advice on smoking cessation was carried out opportunistically and through new patient health checks.

Good



Summary of findings

The practice offered extended opening hours alternate Tuesdays and Thursdays till 8pm and on alternate Saturdays between 8am and 12.30pm as well as daily telephone consultations. This benefitted people who were unable to attend the practice during working hours.

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

The reception desk was constructed with a cut-out section at low level that enabled patients in wheelchairs to talk with reception staff at an appropriate height.

Patients whose first language was not English were supported to understand their needs by involving interpreters in the discussion of their care and treatment and booking extended appointments when this was required.

Home visits and telephone consultations were available for people who could not get to the surgery. There was also single, low level access for people with restricted mobility.

People with a learning disability were identified on a register and their care, including their physical health was proactively managed This included an annual health check.

The practice had vulnerable adult safeguarding protocol in place and followed guidance set out under the Mental Capacity Act 2005 to assess the capacity of certain patients to consent to care and treatment where that capacity was in doubt.

The practice accepted patients on a temporary residence basis if this was required and any person whose treatment was regarded as immediately necessary. The practice met the needs of people living in a local homeless men's shelter and the manager of the centre was also a member of the patient forum.

The practice had vulnerable adult safeguarding protocol in place and followed guidance set out under the Mental Capacity Act 2005 to assess the capacity of certain patients to consent to care and treatment where that capacity was in doubt.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

The practice referred patients to an independent well-being counselling service that ran weekly counselling sessions at the

Good



Summary of findings

practice. There were good links to local mental health services. For example, the mental health charity, MIND, was represented on the patient forum. The practice had provided some phlebotomy services for patients who had mental health needs where travel to the usual local phlebotomy service would be stressful and anxiety provoking. This was an area of outstanding practice.

GPs recognised that some patients with mental health needs expressed a strong preference for their usual doctor and so the practice made arrangements to facilitate this need by accommodating double appointments at the end of sessions wherever possible.

There were triggered, opportunistic health screening for patients with dementia who were recognised by the computer system to have other contributory illnesses or conditions such as diabetes or lung conditions. Patients with dementia were also reviewed at least annually for a check on their physical health as well as for a review of their mental health needs and to ensure that they were properly engaged with the community mental health services. The care of people with dementia was managed through the proactive care arrangements.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection including the chair of the patient forum (PF), a group of patient's representatives and staff set up for the purpose of consulting and providing feedback in order to improve quality and standards. Everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice and that they were provided with plenty of information about their care and treatment. They also reported that they could easily get an appointment and that the practice was responsive to their needs.

We collected 24 comment cards that had been left for us by patients in advance of our visit. Only wholly positive experiences of patients were reported on the comment cards with none of the cards indicating any negative or critical views. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We reviewed data from the most recent national patient survey. We noted that 86% of patients stated they would recommend the practice with 88% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally. Generally the survey indicated a positive experience of patients with satisfaction rates higher than the national average, particularly for opening hours and appointment availability, which were among the best nationally. The survey showed marginally lower than average satisfaction rates for care and concern showed by the doctors and involvement in care and treatment. However, this was at odds with the views of patients we obtained on our visit and expressed through the comment cards.

Areas for improvement

Action the service SHOULD take to improve

The practice should take steps to ensure every staff member who might perform the role of chaperone has appropriate training.

Outstanding practice

The practice had taken steps to meet the need of patients with poor mental health by introducing phlebotomy services where travel to the local phlebotomy service might be stressful and anxiety provoking.

Dr Hogg and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by another CQC inspector and a GP specialist adviser.

Background to Dr Hogg and Partners

Dr Hogg and Partners, also known as Parklands Surgery is a community general practice that provides primary medical care for around 12,000 patients who live in the town of Rushden, Northamptonshire and the surrounding area. According to Public Health England, the patient population is predominantly white British with a slightly higher than average percentage of patients aged over 40 years as compared with the rest of England. There is a less than average percentage of patients in the age range 20 to 39 years and a lower percentage of patients aged under nine years.

Dr Hogg and Partners has seven GPs, five male and two female, all of whom are partners in the practice. There are five practice nurses who run a variety of clinics as well as members of the community nursing and health visiting team who operate from their own offices in the practice building.

There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8am and 6.30pm, Monday to Friday with

additional hours till 8pm on alternate Tuesdays and Thursdays and alternate Saturday mornings. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was 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 in this round of inspections in the Nene Clinical Commissioning Group (CCG) area.

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

How we carried out this inspection

We conduct our inspections of primary medical services, such as Dr Hogg and Partners, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

Detailed findings

We carried out an announced visit on 10 October 2014. During our visit we spoke with three of the GPs, the practice manager, members of the nursing team, administration staff and a medical student on a work placement.

We spoke with five patients using the service on the day of our visit one of whom was a member of the patient participation group that the practice referred to as their patient forum (PF). We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 24 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them.

Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

We found that Dr Hogg and Partners had an open and transparent culture amongst its staff about keeping people safe. This was supported by clear procedures for escalating incidents and allegations of abuse through the practice manager. The practice also made use of short, informal daily 'coffee meetings' at the end of regular morning surgery hours where all medical, nursing and available administrative staff attended. Staff at all levels were encouraged to communicate any incidents and concerns arising from the morning's work straightaway so they could be discussed and dealt with immediately. Any matters requiring further investigation or more detailed discussion were escalated through the significant event process.

Staff we spoke with demonstrated a broad understanding of the processes for reporting such incidents and knew the extent of their accountability.

We saw that the practice took account of a number of different sources of information to help them to understand whether or not they were operating safely. We looked at complaints records, comments received, records of incidents and notes of management meetings. These records showed that incidents, feedback and concerns were discussed at practice management meetings. Outcomes and any learning arising from the incidents were communicated to staff through staff practice meetings.

The practice also made use of clinical audits to ensure they were working safely. For example, we saw an audit that had been carried out on infection rates following minor surgery which showed no post-operative infections.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and analysing significant events, incidents and accidents. All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation. The non-hierarchical management approach supported this learning culture.

Safety issues and significant events were discussed as a standing agenda item on each monthly practice management meeting where key decisions were made about the practice. Significant events that affected the wider clinical team, including the practice nurses, attached

community nurses and health visitors, were discussed at every third meeting at which those staff members were present. This ensured that key lessons were shared among all relevant staff. For example, we noted that a safety issue had arisen in relation to nursing staff working when staff levels were otherwise low. As a result, the clinic timetable was adjusted to enable practice nurses to work in adjacent rooms on such occasions.

We looked at a number of records of significant event analyses (SEA) which demonstrated that the practice reviewed the circumstances of such events and learned lessons from them. For example, we looked at a SEA relating to the response to a patient who became suddenly unwell in the practice but where there had been no detrimental consequences. This incident was investigated and this resulted in a heightened awareness among all staff about the need to summon a doctor immediately in the event of a serious acute illness.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were regular meetings with the Health Visiting service to manage and review risks to vulnerable children. Practice training records made available to us showed that all staff had received relevant training on safeguarding to the level appropriate to their role. We asked members of the 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 about documenting safeguarding concerns and how to contact the relevant agencies during and out-of-hours. Contact details for the relevant agencies were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to the appropriate level to enable them to fulfil this role. All staff we spoke with were aware who their lead was and how to escalate concerns they might have about particular patients.

There was a system to highlight vulnerable patients on the practice's computer system. Staff we spoke with told us that this included information on specific issues so they were aware of any relevant background when patients attended appointments; for example children subject of a child protection plan.

Are services safe?

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals or other services. Access to this system was through a smartcard and a unique password. The practice used minimal paper patient records. Where paper records were used these were filed away securely after use in accordance with a clear desk policy which required all staff to lock away paper documents with confidential personal information.

Medicines Management

We found that the practice operated a safe repeat prescription process; prescriptions could be ordered through the practice, through the pharmacy next door or through any other local pharmacy. Staff who were responsible for managing the repeat prescription process were trained to do so. The practice followed a standard repeat prescription timescale of 'within 48 hours'. Feedback we received from patients about their prescriptions was good and they reported that they experienced no delays in obtaining their medicines and that they always received the medicines they needed.

All prescriptions were reviewed and signed by a GP before they were issued to a patient. Blank prescription forms were tracked through a record keeping system and were held securely at all times.

The practice regularly monitored the way it prescribed medicines. Patients on regular medicines over a prolonged period of time were checked to see that their prescription was appropriate and continued to meet their needs. We saw that the process for re-issuing repeat prescriptions that had gone beyond their stated renewal date was robust. This process involved a comprehensive assessment according to the patient's needs, such as blood tests or clinic appointments with a practice nurse, before medicines were re-prescribed. Patients we spoke with confirmed that they were regularly recalled for the appropriate medicine reviews and blood tests.

We found that all medicines stored at the practice, including vaccines and emergency medicines were managed and stored safely. Medicines stored in the treatment rooms and refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the

required temperatures from the time they were received, to the time they were used. This was being followed by the practice staff who understood the importance of maintaining these temperatures.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked, including those intended for emergency use, were within their expiry dates. Expired and unwanted medicines were returned to the pharmacy for disposal.

The practice did not hold any stocks of controlled drugs.

Cleanliness & Infection Control

We saw that the premises were clean and tidy. Treatment rooms where minor procedures, including surgery, were carried out were maintained appropriately for this purpose. We saw there were cleaning schedules in place and cleaning records were kept that helped the practice to monitor the effectiveness of the cleaning process. The practice had a separate cleaning schedule which specified how and when clinical equipment, such as thermometers and blood pressure measuring devices should be cleaned.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a protocol to be followed in the event of anyone suffering a 'needle-stick' injury.

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 to carry out staff training. All staff had received an annual infection control training update which was completed online.

Notices about hand hygiene techniques were displayed above every hand-washing sink in the treatment rooms and in all of the toilets. Hand-washing sinks were all equipped with hand gel and hand towel dispensers. We saw that the infection control lead had carried out audits on hand-washing in February of 2014 and had subsequently issued guidance to refresh the knowledge of all staff on correct hand-washing procedures.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

Are services safe?

environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks of the water supply in line with this policy in order to reduce the risk of infection to staff and patients.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or hygienic practices.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the asthma clinic, and procedures, such as minor surgery.

Staff told us that all equipment was tested annually and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors, a spirometer and an electro-cardio gram (ECG) machine were regularly calibrated to ensure they were operating safely and effectively.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people being employed. For example in the two staff records we reviewed we saw proof of identification, references, qualifications, registration with the appropriate clinical professional body and, if applicable, criminal records checks through the Disclosure and Barring Service (DBS).

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The recruitment policy only required DBS checks to be undertaken for clinical staff. The practice manager described to us the process for risk-assessing non-clinical staff to determine their eligibility for a DBS check although such risk-assessments were not documented in the staff members' personnel files.

A GP talked us through the arrangements for planning and monitoring the numbers and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they

were enough staff on duty. There was also a 'buddy system' arrangement in place that ensured staff members could cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staffing levels were set based on the number of patients registered with the practice and adjusted depending on demand throughout the week. We saw that staff were allocated to reception duties during busier periods and that other administrative tasks were carried out at less busy periods. 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 ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

We saw that the practice had procedures in place to deal with potential medical emergencies including an emergency button in each room and on each computer terminal. All staff had received training in basic life support and received update training annually. This included a training drill on responding to patients suffering anaphylactic shock associated with an allergic reaction to vaccines.

Staff had access to an automated external defibrillator (AED), a device used to restart the heart in a medical emergency as well as emergency oxygen. The practice carried a stock of medicines for use in the event of a medical emergency. These included medicines for use for people experiencing chest pain, a diabetic emergency or anaphylactic shock. The emergency medicines were checked weekly to ensure they were within their expiry dates.

When patients called in to book an appointment they were asked how urgent their need was and whom they wanted to see. Administration staff who booked patient appointments had access to information about each member of the GPs and nursing staff's specialities so that patients were booked in to see the most appropriate person.

Furthermore, we noted that a culture of empowerment existed among staff at all levels where they could share immediate concerns about risks to individual patients with a clinician. For example, the SEA we reported earlier in this

Are services safe?

section arising from a person who had become acutely ill in the reception area. Staff we spoke with said they were confident they could recognise patients who might have acute needs requiring a clinician's input as a priority.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The document was kept under review and hard copies were located both on and off-site. Identified risks were included on a risk log. Each risk was assessed, rated and control actions recorded to manage the risk. These were discussed at GP partners' meetings to ensure any changes in risks were identified and properly managed. For example, some members of

staff had been designated as deputy for some of the practice manager's functions whilst other tasks had been delegated. This enabled the practice to be assured there was resilience for key management activities.

We learned that the practice had suffered a lightning strike in 2013 resulting in a serious disruption to the practice telephone system. The practice contingency plan had called for the maintenance of a separate telephone line. This line had been maintained and the practice was able to divert all calls to it from the affected system. This had resulted in the practice remaining functional within a few hours then fully operational once more within 48 hours. We noted that the practice had learned lessons from this incident and had made some minor amendments to their contingency plan as a result.

We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We saw that practice management meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were assimilated during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice.

The practice's daily, informal coffee meetings, held for all available staff after the morning's surgery, also created a forum for staff to discuss clinical issues that had arisen during the morning's sessions.

The practice used their computer records system through the quality and outcomes framework (QOF) to identify and monitor particular patients within certain groups and to tailor any interventions according to their need. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. For example, the practice identified and recalled patients with long term conditions so that their conditions could be monitored effectively. In this way the practice had also identified which of its patients were most at risk of unplanned hospital admissions and had developed individual care plans so that their care could be delivered proactively. The practice also employed a member of staff whose role was to 'track' information about such patients and to monitor their care plans. This was so their reviews could be carried out on time, any emerging risk factors could be identified early and interventions planned.

We also saw that the practice appropriately coordinated the multi-disciplinary team (MDT), comprising the community nursing team and the Macmillan service, for the planning and delivery of palliative care for people approaching the end-of-life. The MDT is part of the arrangements required by the quality standards for end-of-life care described by NICE. We saw that every patient receiving palliative care was reviewed by the MDT at formal monthly meetings to ensure that their specific

needs were met. This was particularly effective at this practice since the community nursing teams were based on site and had opportunities to discuss individual patients' evolving needs face-to-face when required.

During our interviews with GPs and staff and throughout our observations we saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. The practice had taken steps to assure the reliability of the data produced by these searches by using particular software that ensured standardisation and accuracy.

To support this, the practice also ran a comprehensive programme of clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness.

For example, we looked at completed audit cycles that had examined the practice performance for treating patients who were identified at high risk of vascular disease and for assessing the usage of aspirin in patients who had had a stroke. One particular audit we examined showed that around 600 patients were identified as diabetic; this was a high proportion, 5%, of the patient population and was reflective of the practice's proactive approach to identifying diabetes. The audit also enabled the practice to identify 22 patients who had not had an annual review and for the practice to trigger an intervention for each of these patients.

We saw that the GPs undertook peer reviews of all referrals to hospitals and other specialist services and the outcomes. This was carried out retrospectively so as not to delay the referral for the patient whilst providing an oversight for the purpose of learning and establishing consistency. Once each month, a list of all the referrals made by the GPs was reviewed by one of the GPs with the process being rotated between the doctors every month. In this way, each GP had the opportunity to review their colleague's referrals and provide feedback and discussion

Are services effective?

(for example, treatment is effective)

as part of a formative process. We noted that this process had enabled the practice to analyse a seemingly high referral rate in gynaecology as compared to other practices in the CCG area. The practice were able to demonstrate that this was not due to differential referral practice but that it was appropriate due to the particular case mix at that time.

Effective staffing

We looked at records and spoke with staff and found that staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. All of the GPs had their own areas of expertise which enhanced the service they were able to provide to their patient population. For example, one GP had expertise in diabetes, another specialised in rheumatology whilst another GP had expertise in ophthalmology.

New staff received a comprehensive induction programme that introduced them to their role. Non-clinical staff were trained to carry out more than one role; for example, all administrative staff could carry out reception duties to enable the practice to remain effective during peak times. We saw that all staff received regular training in subjects that are generally considered as key, such as annual basic life support training and annual safeguarding training. All the nursing staff were multi-skilled and had been trained in various aspects of practice nursing so that they, too, could cover the range of clinics that the practice ran. For example, practice nurses had undergone training in asthma care, management of chronic lung conditions, contraception and eye care. The practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties.

The doctors and the nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies.

The practice had arrangements to provide clinical supervision which is an activity that brings clinicians of like professions and skills together. As we have referred to earlier in this report, the daily informal coffee meetings that took place straight after the morning session provided all staff, but particularly the doctors and the nurses, with the opportunity to discuss clinical issues that had arisen and

from which learning could be obtained. More formal discussion took place at monthly protected learning time (PLT) sessions where key decisions were communicated to staff as well as providing the opportunity for training.

All staff received annual appraisals which identified their learning needs and other development opportunities. Their annual activity was objective driven with a personal development plan agreed at each appraisal. Staff appraisal schedules confirmed that this had taken place and staff we spoke with told us that they felt supported, skilled and valued.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team, the health visitors, the emergency department of the local hospital and the local ambulance service. The evolving needs of every patient receiving palliative care were discussed at monthly multi-disciplinary team (MDT) meetings. As patients neared the very end of life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service to ensure that specific wishes about their death could be met.

All records of contact that patients had with other providers were received by fax or post. They were scanned into the records system for clinical review by the patient's usual doctor if they were available or by a GP designated as 'duty doctor' for the day if they were not. This ensured that the practice retained clinical oversight of their patients' encounters with other health services and could coordinate any further or follow-up action indicated by them.

Further evidence of the effectiveness of the arrangements with other services was the relationship the practice had with the community nursing team and health visitors who had their offices in the practice building. This provided opportunities to discuss individual patients' needs face-to-face, particularly in relation to those patients who were receiving palliative care or those who were at risk of unplanned hospital admissions. A team of advanced nurse practitioners employed by the CCG were also based in the practice and their role was to provide additional nursing support and advice to patients in local care homes in addition to the district nursing service. Although not employed by the practice, we learned that the service the

Are services effective?

(for example, treatment is effective)

practice was able to offer to the care homes covered by these nurses was enhanced because of the closeness of the working relationship and the ability to share information as and when required.

Furthermore, the practice maintained a separate mobile telephone which was handed over from day-to-day to each duty doctor. This number was supplied to the ambulance service and to the local care homes so that they could call the duty doctor direct, bypassing the practice switchboard. We learned that this was used infrequently, and only ever in an emergency so that it was not over-used and its importance was preserved.

We saw that there were information leaflets and posters in the waiting areas. This literature contained up to date information and contact details for local health and care services, such as mental health services and breast screening. To support this, the practice website also had a dedicated page linked to NHS Choices to help patients find local health care services such as hospitals, dentists, chemists and independent healthcare providers.

The GPs also provided some services to the local health economy due to their expertise in certain areas. For example, one of the GPs specialised in rheumatology and provided occasional sessions at the local hospital. Another GP had expertise in ophthalmology and received referrals from other practices in the area.

The practice actively promoted engagement with a local carer's association which provides a gateway to additional local and national support organisations for those who care for others. Patients who were identified as carers were provided with information about this service and the task of monitoring their care and treatment was assigned to a staff member that the practice had designated as 'carer's champion'. The practice had received an award from the carer's association in 2013 and a representative from the association was also a member of the practice's patient forum (PF).

We saw that the practice also enabled access to an independent well-being counselling service that ran weekly counselling sessions at the practice. Patients who needed this service were referred directly to the service from the practice. We noted that the mental health charity, MIND, was also represented on the PF and this was evidence of the practice's effective and meaningful engagement with other organisations.

Information Sharing

The practice used an established electronic patient records management system (known as EMIS) to provide staff with sufficient information about patients. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk. For example, for patients who were caring for others, the caring responsibility was marked on the summary record of a patient when they attended the surgery as a patient in their own right so that the social and psychological factors associated with caring for others could be addressed in care planning.

The system also enabled correspondence from other health care providers, such as discharge letters or blood and other test results, to be scanned and held electronically to reduce the need of paper held records. The practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital outpatients. This system was readily available and accessible to all staff.

Further, the practice had begun to use software that integrates with the EMIS system to help to manage information about referrals to other services. We were unable, however, to determine how effective this system was due to its recent implementation.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented, in the case of, for example, minor surgical procedures or the fitting of an intrauterine contraceptive device. For such procedures the practice used template forms that were taken from the practice computer system. These forms explained the procedure or process in detail to enable patients to fully understand their treatment. Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone

Are services effective?

(for example, treatment is effective)

with parental responsibility. We also saw that the provisions of the Mental Capacity Act 2005 were used appropriately and that assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or who lived with dementia. Each consulting room work-station had a Mental Capacity Act toolkit which helped GPs to reach decisions about a person's capacity to consent. We saw that staff had also received training in the Mental Capacity Act and that relevant guidance to support staff was available on the practice's computerised document system.

Health Promotion & Prevention

All new patients were encouraged to make an appointment for a consultation with a GP when they registered with the practice. This enabled the GP to focus on particular areas of health concern when they saw them for their first appointment. The practice asked patients to complete a new registration form which included information about their lifestyle and social factors. The GP was informed of all health concerns detected and these were followed-up in a timely manner

The practice also used the flu clinics as an opportunity to support and educate patients. Patients were also offered any outstanding health checks required and offered additional vaccines, such as shingles and the pneumococcal vaccine.

We found that there was a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing; for example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering additional help. For example, the practice kept a register of all patients with learning disabilities and offered an annual physical health check. The practice did not currently offer the NHS health check for patients aged 40 to 70 years but offered these opportunistically during other health consultations. The practice intention was to start the NHS health check programme once the tendering process for this activity had been completed by the CCG.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was comparable with that of the rest of the practices in this CCG area, and there was a clear policy for following up patients who did not attend.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with five patients on the day of our inspection including one member of the practice's patient forum (PF), often referred to as a patient participation group. All of the patients we spoke with reported that their GP, the nurses were courteous, considerate and compassionate. Patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception area when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk. For example, we noted that one of the doctors was running slightly late with consultations due to an emergency. The reception staff member conveyed this information to waiting patients on that doctor's list, apologised and explained the reason for the delay.

Patients could be taken to an interview room to the side of the reception if they wanted to speak in private to a receptionist and there were notices displayed advising that this was available.

We also reviewed 24 comment cards that had been collected from patients in advance of our visit. None of the comment cards indicated any negative or critical opinions and all of the cards reported wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2014 National Patient Survey, carried out on behalf of the NHS and reported on the NHS Choices web-site. We noted that 86% of patients stated they would recommend the practice with 88% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally. 100% of patients reported that the reception staff were helpful with 73% reporting that they were satisfied with the level of privacy in reception. This was higher than the national average. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (77%) and by their doctor (70%). This was

slightly lower than the national average and was somewhat at odds with the comment cards we reviewed, the view of the patients we received during our visit and our observation throughout the day. .

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor. Nursing and other clinical staff were primarily used as a chaperone. If nursing staff were not available to act as a chaperone receptionists undertook this role. However reception staff had not undertaken training to perform this role. The practice should take steps to ensure every staff member who might perform this role has appropriate training.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2014 showed that, on average, 77% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them. 69% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were slightly lower than the average for both the local Clinical Commissioning Group (CCG) area and for England in general. The corresponding figures for the nursing staff however, were slightly higher than average.

Our interviews with patients on the day of our visit showed that patients were satisfied with their level of involvement with some reporting that they felt in control. Patients told us that their diagnoses were explained well by their GP and that they had opportunities to ask questions. They said this enabled them to make informed decisions. Further, many of the 24 comment cards we reviewed reported that patients felt listened to.

We found that patients who were referred onwards to hospital or other services were involved in the process. Doctors we spoke with told us that referrals on the 'choose and book' system were made with the patient still in

Are services caring?

attendance and that referral letters were dictated into the electronic dictation system whilst the patient was still with the doctor. We verified that this took place during our interviews with staff and patients.

The practice also had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, there was a board in the private, staff area of the practice that alerted staff to the names of the patients

who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice and offered a visit by one of the GPs, the purpose of which was to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services.

The practice also enabled an independent well-being service to run a counselling service at the practice every week and patients were referred directly to this service by the GPs.

As we have reported above, patients who were identified as carers were provided with information about a local carer support service and referrals to this service were actively managed by a designated 'carer's champion'.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the computerised patient records system to help them to identify patients who might be vulnerable or have specific needs. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved.

The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as children who were known to be at risk of harm. This was also the case for patients who were caring for others as we have reported above.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and a dedicated smoking cessation clinic.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a proactive care (PAC) register and the practice had employed a dedicated PAC coordinator to oversee the management of their care plans. We saw that this enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments and clinical consultations on the telephone.

Patients we spoke with on the day of our visit said they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this prevailing view of the responsiveness of the practice.

Tackle inequity and promote equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For

example, we saw that the practice had provided some phlebotomy services for patients who had mental health needs where travel to the usual local phlebotomy service would be stressful and anxiety provoking.

We also saw that patients with mental health needs were able to book consecutive appointments to see the GP of their choice. The fact that such patients generally expressed a strong preference for particular GPs was recognised within the practice and arrangements were made to facilitate this need by accommodating two consecutive appointments at the end of sessions wherever possible.

There was also opportunistic health screening for patients with dementia who were recognised by the computer system to have contributory illnesses occurring at the same time such as diabetes or lung conditions. This triggered additional assessments by the GP, in addition to any routine assessments that would be initiated in consultations. Further, we saw that patients with dementia were reviewed at least annually for a check on their physical health as well as for a review of their mental health needs and to ensure that they were properly engaged with the community mental health services. The PAC arrangements and the carer initiatives as reported above were also engaged for patients with dementia.

We saw that the practice web-site had an automatic translation facility which meant that patients whose first language was not English could gain 'one-click' access to information about the practice and about NHS primary medical care. We saw that interpreters were arranged in advance and that two consecutive appointments were arranged for patients who needed an interpreter to enable time for translation.

The practice had level access throughout for patients who used wheelchairs as well as wider doors and accessible toilets. There was also a functioning hearing loop in reception and one of the doctors was accomplished at using sign language to assist patients who had difficulty hearing.

Access to the service

The practice is located in an area which has a higher than average proportion of working age people over 40 years of

Are services responsive to people's needs?

(for example, to feedback?)

age. In order to meet the needs of this group of patients the practice opened for late consultation appointments until 8pm on alternate Tuesdays and Thursdays and between 8am and 12.30pm on alternate Saturdays.

Some appointments were released for booking up to two months in advance with the remainder being made available on the day. Patients who wished to be seen in an emergency were offered an appointment slot towards the end of surgery opening times but once these were full, patients were asked to come to the surgery to wait for the next available doctor. Telephone consultations were also offered to patients at the end of normal surgery hours. Doctors also carried out home visits to patients who were unable to get to the practice.

Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system. Call-handling was carried out as a 'back-office' function and during busy times additional staff answered the telephones to ensure patients did not have to wait longer than necessary for their call to be answered.

The 2014 National Patient Survey results showed that patient satisfaction with the practice's opening hours was among the top 25% in the country whilst patients' satisfaction with their experience of making an appointment was at 92%. The survey also showed that 98% of patients said they found it easy to get through on the telephone, also among the best. On the day of our inspection, all five of the patients we spoke with said that they were happy with the appointment booking system

and that they appreciated being able to make an emergency appointment on the day. Comment cards we received were also positive about the appointment system with several patients particularly commending the practice about appointment availability.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was 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. There was information on the practice website, in leaflet form in the reception area and in a notice on the notice board advising patients of the complaints procedure. All of the patients we spoke with said they had never had cause to complain told us they would know how to complain if necessary.

We looked at the complaints received in the last twelve months and that these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints on an ongoing basis and reviewed these regularly at partner and team meetings. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. We saw an example where, following a complaint, the practice was working with clinicians to improve the way they communicated with patients during consultations.

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 web-site carried their vision statement which was centred on providing the highest quality healthcare. This was reflected in the practice's statement of purpose they had submitted to the CQC as part of their registration responsibilities with the principal aim stated as 'To provide high quality, accessible health care to our practice population without discrimination'. It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that put outcomes for patients first.

The GPs, practice manager and the staff we spoke with often referred to the 'patient journey' as being at the heart of their approach and this demonstrated that all staff had thought about and adopted this key value. Throughout our visit we saw a consistent, kind, caring and compassionate approach to patients that supported this assertion.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for areas such as safeguarding, prescribing, proactive care (PAC), patient forum (PF) and clinical audits. These responsibilities were shared between the GP partners. In addition, one of the GPs represented the practice on the locality group within the CCG area, a group of nine practices that met to monitor and direct local primary care services.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The practice also actively used feedback from complaints, concerns and the findings of significant event analyses (SEA), clinical audits and referral peer reviews to understand and manage any risks to their service. We looked at a number of examples of each of these as previously reported above.

Decision making and communication across the workforce was structured around key, scheduled meetings as well as

benefitting from some informal and more dynamic dialogue between staff which we have reported on below. The partners and the practice manager met at monthly practice management meetings to discuss the business and the things that had an impact on its effectiveness. These included QOF data, clinical audits, SEAs and complaints. For example, we looked at the notes of the meetings of September and October 2014 at which the practice's performance in relation to unplanned hospital admissions were initially discussed and then updated on at the following meeting.

Issues that affected the wider clinical team, including the practice nurses, attached community nurses and health visitors, were discussed at every third meeting at which those staff members were present.

For all staff, monthly protected learning time (PLT) sessions often doubled as all staff meetings where key decisions were communicated to the whole team.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Despite the clear formal meeting structure the practice operated an egalitarian approach to staff involvement and decision making. This non-hierarchical approach encouraged staff to contribute their views and to have some ownership of the delivery of the practice vision.

For example, the practice featured a daily, informal coffee meeting that took place for a short time immediately after the end of the morning's surgery. All available medical, nursing and administrative staff attended. Any incidents and concerns arising from the morning's work were discussed and dealt with immediately or escalated for further investigation or more detailed discussion in a more formal process.

We spoke with staff about this approach and they told us they felt valued and able to contribute. The practice manager explained that there was a low turnover of staff in all roles. We noted that staff were positive in their attitudes and presented as a happy workforce. We considered this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

Are services well-led?

Good 

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

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

In addition to the engagement with staff, the practice also engaged effectively with its patient forum (PF). Such groups, often referred to as patient participation groups, are made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. One of the partner GPs had the designated lead role for the PF at the practice which met quarterly.

We learned that the PF had participants from diverse backgrounds ranging in age from under 25 to over 70. However, a significant majority of the group were aged over 60. We spoke with the chair of the PF on the day of our visit who said that the membership was around 22 but with 12 to 14 people who regularly attended the meetings.

In addition to patients, the PF at this practice also had members from key local organisations that also took part. These included a member from the local carer's association, a member from the local branch of the mental health organisation, MIND, and the manager of a local homeless men's shelter. In this way the PF was representative, not only of the local patient population but also of local minority groups with particular needs. We saw that this relationship had been effective because, for example, the practice had introduced phlebotomy services for mental health patients where travel to the local phlebotomy service might be stressful and anxiety provoking. We consider this to be an area of outstanding practice.

The PF also carried out its own annual survey of patients, the most recent survey being carried out at the end of 2013. The practice had responded to the findings of the latest and previous surveys. For example, changes to the car park traffic flow to improve safe entry and exit whilst local building works were going on; the provision of a comments box in reception and the production of a newsletter.

Management lead through learning & improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through protected learning time.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working. It was clear to us that everyone who worked at the practice found the daily informal coffee meetings to be of great benefit. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.