Northumberland House Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 28 November 2014 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Information showed that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw areas of outstanding practice including:

- Two GPs at the practice provided specialist support for patients with mental health conditions. GPs told us they held weekly mental health clinics and drug and alcohol recovery clinics, but often met the needs of these patients outside these clinic times. We saw a comment from a patient who had experienced mental health problems. They had appreciated the support the practice had given them when they felt there had been no one else there for them.

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

The provider should:

Summary of findings

- Review their recruitment policy and procedures to ensure that all checks according to Schedule III of the Health and Social Care Act 2008 are carried out when staff are recruited.
- Establish a system to ensure that minutes of all meetings accurately record discussions that take place to provide an audit trail of information sharing, learning and outcomes.
- Establish a system to ensure that details of all clinical audits carried out by GPs are shared routinely. This would ensure best practise, knowledge and awareness is disseminated throughout the practice in a formal way.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events over time. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Risks to patients were assessed and well managed. There were enough staff at the practice 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. National Institute for Health and Care Excellence(NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

A schedule of appraisals and the personal development plans for all staff had been planned. Staff had received training appropriate to their roles and further training needs had been identified and planned. Multidisciplinary working was evidenced.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy with patients as their main focus and priority. High standards of care were promoted by all practice staff with evidence of team working across all roles. 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 regular governance meetings had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon where improvements had been needed. Patients were very positive and spoke highly of the practice. Staff felt they were valued as members of a caring and responsible team.

Summary of findings

What people who use the service say

We spoke with 12 patients on the day of the inspection. Patients told us they were extremely satisfied with the service they received at the practice. They told us they were very happy with the treatment they received and that staff were always very kind and helpful. Patients told us they were always treated with dignity and respect.

We reviewed the 15 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that 14 of these comments were extremely positive. Patients had commented that they were impressed by the service they received from the practice. They told us that staff were always friendly and that they thought the practice was caring. Some patients commented that the GPs were very good at listening to them and the GPs did not make them feel rushed when they were upset. One comment indicated that a patient had found their experience at the practice had been less positive, but there was insufficient information provided that we or the practice could follow up with the patient concerned.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment and on the same day of contacting the practice.

We looked at the national GP Patient Survey for 2012/2013 and found that patients were generally satisfied with the appointments system. Data showed that 88% described their experience of making an appointment as good; 84% were satisfied with the practice's opening hours and 89% would recommend this practice to someone new to the area. All these results were above the national average.

Areas for improvement

Action the service SHOULD take to improve

- Review recruitment policy and procedures to ensure that all checks according to Schedule III of the Health and Social Care Act 2008 are carried out when staff are recruited.
- Establish a system to ensure that minutes of all meetings accurately record discussions that take place to provide an audit trail of information sharing, learning and outcomes.
- Establish a system to ensure that details of all clinical audits carried out by GPs are shared routinely. This would ensure best practise, knowledge and awareness is disseminated throughout the practice in a formal way.

Outstanding practice

- Two GPs at the practice provided specialist support for patients with mental health conditions. GPs told us they held weekly mental health clinics and drug and alcohol recovery clinics, but often met the needs of these patients outside these clinic times. We saw a comment from a patient who had experienced mental health problems. They had appreciated the support the practice had given them when they felt there had been no one else there for them.

Northumberland House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP specialist advisor. The team also included a second CQC inspector, a practice manager and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Northumberland House Surgery

Northumberland House Surgery is located in Kidderminster in Worcestershire and provides primary medical services to patients. Northumberland House Surgery has a Personal Medical Services (PMS) contract although the practice will be changing to the General Medical Services contract (GMS) in due course. A PMS contract pays GPs on the basis of meeting set quality standards and the particular needs of their local population. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities and replaces the PMS contract. The practice covers Kidderminster and the surrounding areas such as Bewdley and Stourport on Severn.

Northumberland House Surgery is an approved GP training practice for registrars. Fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP. The practice also supervises a number of medical students from the University of Birmingham.

The practice has four male and three female GP partners, one salaried GP, a practice manager, a deputy practice manager, three nurse practitioners with one nurse practitioner who has extended duties such as prescribing certain medicines and referring patients for tests; six nurses, two healthcare assistants, administrative and reception staff. There were 12258 patients registered with the practice at the time of the inspection. The practice is open on Mondays from 8am to 6.30pm Monday to Friday. Extended hours pre-booked appointments are available from 8am to 11am for one Saturday per month. During winter months the practice makes appointments available throughout the day on Saturdays to facilitate increased demand during this time. Home visits are available for patients who are too ill to attend the practice for appointments.

The practice treats patients of all ages and provides a range of medical services. The services provided are in ratios similar to those shown by average practices according to Public Health England information August 2014. Northumberland House Surgery shows a higher percentage of deprivation across the population groups. This is currently 26% when compared with 23% of the national average. The practice population has a life expectancy of 78 years for males and 82 years for females compared to the national average of 79 years for males and 83 years for females.

The practice provides a number of clinics such as disease management, diabetes, weight management and

phlebotomy (taking blood) clinics. It offers child immunisations, minor surgery and family planning services. Practice nurses can be seen by appointment for blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. Nurses take various lead roles, such as weight management, infection control, smoking cessation and dementia. The practice does not provide an out of hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

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

Before our inspection of Northumberland House Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Wyre Forest Clinical Commissioning Group (CCG), the NHS England local area team (LAT) and the Local Medical Committee (LMC) to consider any information they held about the practice. We spoke with the manager of a nursing home supported by the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 28 November 2014. During our inspection we spoke with a range of staff that included three GPs, the practice manager, the deputy practice manager, two nurses, and administration and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the practice. We spoke with 12 patients who had appointments with GPs or Clinical staff.

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 looked at how well services are provided for specific groups of patients and what good care looks like for them. The 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 whose circumstances may make them vulnerable
- People experiencing poor mental health

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, national patient safety alerts as well as comments and complaints received from patients. Staff told us they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that significant events had been discussed at practice meetings over the last year which demonstrated the willingness by the practice to report and record incidents.

We reviewed safety records and incident reports for the past three years. This showed that the practice had managed these consistently over time and could evidence a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last three years and were able to review these. Significant event discussions were a standing item on the weekly business meeting agenda. If necessary these were included for further discussion at the quarterly practice meetings which were attended by the GPs, the practice manager, and a nurse.

We found however that although significant events had been recorded, it was not clear who had recorded them. Some events detailed the action that was to be taken, although there was no evidence to show if or when this had been completed, reviewed or shared. We discussed this with the practice manager and the registered manager who confirmed that they would review the templates they used and develop ways to ensure that all information was captured and reviewed. This would help ensure that evidence was available to provide a clear audit trail that showed what action had been taken, any themes that had been emerged and documented the learning arising from the incidents.

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. Reception staff told us they would report incidents when they occurred to their senior receptionist, who would then escalate these. Staff confirmed that incidents were discussed at staff meetings but the minutes we saw did not accurately reflect the discussions that staff told us had taken place.

National patient safety alerts were handled by the practice manager, the practice nurse and reception staff. The practice manager confirmed that alerts were actioned by the practice nurse in conjunction with the senior GP partner. Information was then circulated by email to the wider teams which included district nurses and pharmacists, with details of action required recorded. For example, we were told that a computer search would be conducted to identify any patients who may be affected. Staff told us that alerts were discussed at clinical meetings to ensure all staff took appropriate action as required.

Reliable safety systems and processes including safeguarding

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

The practice had a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. Two additional staff had been trained to advanced level in safeguarding vulnerable adults and children. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, clinical staff told us they had followed the procedure and shared concerns they had about a patient who had attended a clinic at the practice with unexplained bruising.

There was a system 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. We saw that GPs appropriately used the required codes on their electronic case management system. This ensured that risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults procedures and records demonstrated good liaison with partner agencies such as the police and social services. Staff confirmed that six weekly meetings were scheduled with the health visitor and a GP to discuss any concerns they had about children and young people.

There was a chaperone policy in place and staff were able to access this as required. Information was made available to patients via the practice website and the screen display in the practice waiting room. We saw records that confirmed that nursing staff, including health care assistants had been trained to act as chaperones.

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 confirmed they followed the policy.

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

The nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. For example, we saw that directions for the administration of nasal flu vaccine had been signed by the nursing staff.

A member of the nursing staff was qualified as an independent prescriber, a nurse who was specially trained to prescribe any licensed and unlicensed drugs within their clinical competence. GPs told us that they provided the nurse prescriber with regular supervision and support in their role. They also ensured the nurse prescriber was up to date in the specific clinical areas of expertise for which they prescribed. We saw training records that confirmed this. Nurses confirmed that training was provided to ensure they kept up to date with their clinical expertise, knowledge and skills.

There was a protocol for repeat prescribing which was in line with national guidance. We saw this was followed in practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a process in place to limit the number of repeat prescriptions to ensure that patients' medicines were regularly reviewed.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients told us on the comment cards that they always found the practice clean and had no concerns about cleanliness or infection control. Hand hygiene technique signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw hand sanitation gel was available for staff and patients throughout the practice including the reception area.

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 for couches were available for staff to use. Staff described to us how they used these in order to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training. We saw evidence that the lead had carried out regular audits and that any improvements identified for action were completed on time. Practice meeting minutes showed that the findings of these audits had been discussed. The infection control lead told us they had carried out training for all staff during 2014. We saw records that confirmed this.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff

what to do in the event of a needle stick injury. Staff we spoke with knew the procedures to follow in the event they sustained a needle stick injury. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

The practice had policies and systems in place to protect staff and patients from the risks of health care associated infections. For example, we saw that there was a water flushing protocol in place for the management of Legionella (a germ found in the environment which can contaminate water systems in buildings). This included flushing through showers that were not frequently used. Records were kept to show that these checks had been done.

Equipment

Staff told us they had equipment available so they could carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that portable electrical equipment was clearly labelled and dated as having been tested in 2014.

We saw records that confirmed that measuring equipment used in the practice was checked and calibrated (testing for accuracy) each year to ensure they were in good working order. For example, we saw that calibration of relevant equipment such as weighing scales, ear syringing equipment and the blood pressure monitoring equipment had been checked in August 2014.

Staffing and recruitment

The practice had a recruitment policy and procedure in place that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at staff files to check that appropriate recruitment checks had been undertaken prior to employment. We found that robust recruitment checks had not been completed for all of the records we sampled. For example, information to confirm that proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks where appropriate had not been completed consistently for all the staff files we looked at. We discussed this with the registered manager and the practice manager who confirmed our findings.

Staff told us that arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the 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.

We looked at records that confirmed these checks took place. For example, we saw that the fire system had been inspected by an external contractor annually, and the most recent check had been done on 8 October 2014. A fire risk assessment had been completed in October 2012.

Identified risks were discussed at GP partners' meetings, within team meetings and shared with all staff by email. For example, the infection control lead confirmed that they cascaded information to all staff by email to implement any changes identified through infection control audits. We saw that the last audit had been carried out in 10 June 2014 and the findings and action plan resulting from this had been shared with staff. Staff we spoke with confirmed this.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health

Good

Are services safe?

and medicine reviews, and followed up if they failed to attend. For example, the practice restricted the number of repeat prescriptions issued to ensure medicine and health condition reviews were carried out

Arrangements to deal with emergencies and major incidents

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

Processes were also in place to check whether medicines retained for emergency use 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 in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electrical company to contact if the electrical system failed. There were also procedures to follow in the event of a systems failure to protect records and patients access to the practice. For example, a daily back up of the system was carried out and saved and stored in a fire proof safe. Staff confirmed they were aware of the systems to follow relevant to their roles and responsibilities.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had completed fire training throughout 2013 and 2014 and that they practised regular fire drills. Staff trained as fire marshals worked on both floors of the practice and we saw records that confirmed weekly tests of the fire alarm was carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed. For example, the staff we spoke with confirmed that these discussions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers.

Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it. We were told that clinical leads met weekly. We found recorded evidence of these meetings where they reviewed latest guidelines and best practice.

Patients with long term conditions received an annual needs assessment. We saw management plans for patients with diabetes and respiratory problems. Staff told us that patients were encouraged to be involved with these.

The practice used the gold standard framework (GSF) for managing terminally ill patients. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

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

Management, monitoring and improving outcomes for people

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

We looked at audits completed by the practice over a period of two years. We found there was no clear system in place for a consistent and practice led approach to audits and completed audit cycles.

Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence based standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. A clinical audit is a continuous cycle that is continuously measured with improvements made after each cycle.

We were shown examples of audits, but we found that not all these examples were fully completed audit cycles. The GP we spoke with confirmed that the practice GPs were leads for different clinical areas, such as prescribing, diabetes and respiratory conditions. GPs completed individual audits but there was no system in place to ensure this information was shared routinely with all GPs and other staff where relevant. For example, there was no lead in place for overseeing the audits and ensuring best practice was shared throughout the practice. GPs we spoke with were not able to confirm audit details and results of audits carried out by their peers.

We saw that an audit had been carried out to identify patients diagnosed with heart disease prescribed a medicine highlighted as a risk in a medicines safety alert in June 2013. The audit carried out in March 2014 identified patients who were affected and where the medicine prescribed should be reduced. A re audit completed in July 2014 found that the number of patients taking these medicines had been reduced from 24 to 17 which was a decrease of 30%. The medicine safety alert guidance advised minimal or no usage should be the aim. The

practice confirmed that further audits were needed to ensure that usage of the medicine was reduced. We noted that this initial audit had been completed eight months following the medicines safety alert.

Following the audits, the GPs had not formally shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs had not maintained records showing how they had evaluated the service and documented the success of any changes. The registered manager confirmed this was an area where they needed to make improvements. The registered manager considered that the significant changes undergone by the practice's move to new premises and staff changes that had occurred meant that they needed to refocus on audits and the way they ensured information was used more effectively.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results to measure their performance. QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was on the agenda for regular discussions at the quarterly practice meetings, with actions identified to maintain or improve outcomes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the care had been reviewed within the last 12 months for 95% of patients with a diagnosis of dementia, which was significantly higher than the national average of 84%. In some areas the practice had reached performance levels that were slightly lower than the national average. This was highlighted in performance data that showed the practice had achieved 92% for their total QOF points compared with a national average of 96%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed specific medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe this outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patients' needs.

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

Effective staffing

Staff employed at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with training in areas such as basic life support, infection control and safeguarding vulnerable adults and children. A good skill mix was noted amongst the GPs. GPs had additional interests in areas such as diabetes, asthma, heart disease prevention, dermatology and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a more detailed assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We saw records that confirmed staff had received annual appraisals. We saw that action plans had documented each person's identified learning needs and future objectives had been set. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses. Staff told us that they felt able to ask for further training as opportunities arose and that usually their requests were agreed to. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a training lead GP for support throughout the day.

Registrars (fully qualified doctors who spend 12 months working at the practice to gain the experience they need to become a GP) who worked at the practice told us that they had received a good clear induction and were very well supported. They told us they had no hesitation in taking any concerns to one of the GP partners either during or after a consultation, whichever was appropriate. They had an appropriate understanding of child protection

Good

Are services effective?

(for example, treatment is effective)

procedures and consent. The registrars gave positive feedback about the practice. We also saw positive feedback the practice had received from the University of Birmingham from the medical students who had spent time on placement at the practice.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. Those with extended roles were trained in the diagnosis and management of patients with complex medical conditions such as diabetes and respiratory disease.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which had not been followed up appropriately. Staff told us that any incidents would be discussed in clinical meetings.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, such as those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Clinics were held for blood testing, mental health, dermatology, chiropody, physiotherapy and blood testing within Northumberland House Surgery. A part-time clinical counsellor was employed by the practice to provide support for patients with emotional or psychological problems. Patients could only be referred to the counsellor after they had seen the GP.

We spoke with the manager from a nursing home whose patients were registered with the practice. They told us the practice carried out regular weekly visits to the home. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

A range of information leaflets about local services were available in the waiting room and on the practices website. Some of this information was available in other languages on request. Leaflets in other languages were not routinely displayed and almost all patients spoke English.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (EMIS) was used by all staff to coordinate, document and manage patients' care. Staff told us they were trained to use the system. The record system was also discussed at clinical patient care meetings to ensure a consistent approach in the use of these records by clinical staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to hospital.

Patients registered with the practice had been encouraged to sign up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information. Information for patients about this was available on the practice website, with a form available to enable patients to opt out from having a Summary Care Record if they chose.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act (2005), and assessment of Gillick competency of children and young adults. Gillick competency helps clinicians to identify children under 16 years of age who have the capacity to consent to medical examination and treatment. The GPs and other clinical staff we spoke with demonstrated a clear understanding of the importance of determining whether a child was Gillick competent, especially when providing contraceptive advice and treatment. Staff ensured a child under 16 had the legal capacity to consent to care and treatment. They ensured they were capable of understanding implications of the proposed treatment, including the risks and alternative options.

Staff told us they completed Mental Capacity Act training through an on-line course. Clinical staff we spoke with understood the key parts of the legislation and they were able to describe how they implemented it in their practice. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Clinical staff told us that if they thought a patient lacked capacity, they would ask their GP to review them.

We saw that there were systems in place to obtain and record consent given by patients and that reviews of these decisions were carried out. For example, we saw that consent forms were available for patients to sign to agree to minor surgery procedures. These forms required patients to sign to confirm that they understood the procedure and any potential risks involved before the procedure was carried out.

We saw consent forms signed by parents for children who had received immunisations. Clinical staff demonstrated that they were aware of the need for parental consent and what action to follow if a parent was unavailable. Parents were given information to inform them of potential side effects of the immunisations.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews or to review the patients long term condition.

The practice had numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, staff told us that the practice kept a pre-diabetes register to monitor those patients that had been identified at risk of developing diabetes. Patients were asked to attend for an appointment at the clinic where initial checks would be done, including checks on patients' feet, lifestyle and diet. Patients were given advice on changes they could make to maintain their health, and they were then recalled and monitored annually. Where patients conditions were seen to change referrals were made to the hospital for a six week programme where specialist support was provided.

Summary care reviews were provided by the practice for individual patients. This ensured that out of hours services and hospital services were able to access information about patients to assist in their treatment in the event of an emergency.

Up to date care plans were in place that were shared with other providers such as the out of hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Flu vaccination clinics were held every autumn. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed

Good

Are services effective?

(for example, treatment is effective)

health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as carers support and bereavement services.

We saw that the health and welfare of patients was promoted in the waiting rooms. This included the use of health monitoring equipment for patients who wished to monitor their blood pressure and body mass index (BMI).

Northumberland House Surgery operated a patient carer protocol, to identify carers they could signpost to support agencies for help should they need it. The practice had carer support information available for patients in the waiting room which gave contact details for Worcestershire Association of Carers support group.

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 and a survey of patients undertaken by the practice. The evidence from all these sources showed patients were satisfied that they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated among the best for the Clinical Commissioning Group (CCG) area for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 15 completed cards and all but one were positive about the service experienced. Patients commented that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They noted that staff treated them with dignity and respect. The less positive comment indicated that the patient were unhappy for a different reason. We also spoke with 12 patients on the day of our inspection. They told us they were satisfied with the care provided by the practice. They said they felt staff ensured their dignity and privacy was respected at all times.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consultation room. Curtains were provided in consultation and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations that took place in these rooms could not be overheard. Staff confirmed they ensured that each patient's dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they would provide a chaperone service if patients preferred this. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw leaflets in the reception area and information on the practice website that confirmed this.

We observed that staff followed the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We spoke with the manager of a nursing home supported by the practice. They described to us the caring, professional, supportive attitude of everyone who worked at the practice from GPs, to nursing and reception staff. The home manager told us the GPs were wonderful with the patients, made them feel comfortable and always treated them with respect.

There was a clearly visible notice in the patient reception area and on the practice's website informing patients of their zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them feel more confident in responding to such incidents. They told us following the procedure had helped them to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

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 that they felt supported by staff. Patients confirmed they 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.

The patient survey information we reviewed showed patients responded positively to questions about their experiences of the practice. For example, data from the national patient survey showed 88% of practice respondents reported a good overall experience of making an appointment compared with 78% for the Clinical Commissioning Group (CCG) area; 89% of patients responded that they would recommend the practice to new patients compared with 79% for the CCG area.

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that the patient was always encouraged to be involved in the decision making process. They described that they would always speak with the patient and obtain their agreement for any treatment or intervention even if a patient attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Good

Are services caring?

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care where they chose.

Staff told us that translation services were available for patients whose first language was not English. We saw information about this service in the practice information booklets and on the practices website.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with during the inspection and the comment cards we received were positive about the emotional support provided by the practice. For example, comments confirmed that staff were always helpful and provided support when required. Patients described the support and compassion they and their relatives had received from everyone at the practice. They told us that GPs and clinical staff had given them extra time and support if they had become upset during their appointment.

When patients died the practice contacted families to check their well-being and offered the opportunity to speak with a member of staff at the practice. Information was provided about organisations specialising in providing bereavement support. Notices in the patient waiting room, on the TV screen and on the practice website also signposted people to a number of support groups and organisations. The computer system used by the practice alerted GPs where 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.

We saw that regular multi-agency and cross practice meetings were held and recorded particularly for palliative care. End of life care and bereavement information was available to patients and their relatives/carers in the waiting rooms. This included information to advise patients what to do if a death occurred at home or in hospital. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service. The manager of the nursing home told us that GPs always gave support where it was needed, and this often included the family members of patients at the home.

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 people'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. For example, the practice had committed to an Expert Patients Programme (EPP) at the local hospital which provided courses designed to help patients with long-term conditions. The programme gave patients the tools, techniques and confidence to manage their conditions better on a daily basis. Expert patients were defined as people who lived with a long-term health condition who were able to take more control over their health by understanding and managing their conditions, which it was hoped would lead to an improved quality of life. The programme promoted the view that becoming an expert patient was felt to be empowering for patients with chronic conditions. Clinical staff told us that they had found patients who had trained in self-management tended to be more confident and less anxious, especially for patients with conditions such as diabetes. They made fewer visits to the GP, were able to communicate better with health professionals, took less time off work, and were less likely to suffer acute episodes that required admission to hospital.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to make service improvements and manage the health needs of its population.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions.

Longer appointments were available for patients who needed them and for those with long term conditions. Patients were also given appointments with a named GP or nurse. Home visits were made to local nursing home on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits. The manager of the nursing home told us that the GPs would always attend the home as soon as they called. They told us the GPs and the reception staff were very supportive.

The practice had a register of patients with mental health support and care needs. Each patient on the register was invited for an annual review. Staff explained that they had good working relationships with the local mental health team.

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). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. For example, when the practice first moved to the new building patients found the position of the key pad to exit the car park difficult to manage. The practice reviewed this and put another key pad in place to resolve this issue.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various services and support available to them should they need it.

Female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signage informed patients where to go. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for an interpreter if required and that information could also be translated via the internet. The practice's website offered translation of information into 80 languages for patients.

The practice had equality and diversity policy in place and staff we spoke with confirmed that they had completed this training in the last 12 months. We saw records that confirmed this.

The practice was situated over three floors of the building with most services for patients on the ground floor. There was lift access to the first and second floors. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

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

The practice had produced a comprehensive, detailed booklet which provided patients with information about the practice they could take away with them. This included information that was also available on their website, such as information about all staff, clinics, complaints procedure and details of other agencies where patients could seek further information, help and support.

The practice was open from 8am to 6.30pm Monday to Friday. Extended hours pre-booked appointments were available from 8am to 11am for one Saturday per month.

During winter months the practice made appointments available throughout the day every Saturday to ease the demand for appointments. Home visits were available for patients who were too ill to attend the practice for appointments.

The practice treated patients of all ages and provided a range of medical services. The range of services provided was similar to those ratios shown by the average practices according to Public Health England information. Northumberland House Surgery does show a higher percentage of deprivation of 26% when compared with 23% of the national average across the population groups. The practice population shows a slightly reduced life expectancy for males 77 years and females 82 years compared to the national average of males 79 years and females 83 years.

Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice. Patients confirmed on the comment cards that they could see a GP on the same day if they needed to. They told us they could see another GP if there was a wait to see the GP of their choice. We saw how a GP responded to the needs of a patient who needed regular checks to monitor their condition. For example, the GP told us a patient was unable to attend the usual clinic and usually arrived at the surgery without an appointment, as they relied on transport to get to the surgery. The GP told us they always made time for the patient and fitted them in around their schedules as this made sure the patient continued to be monitored in the way that was required of their condition.

The practice confirmed they held a register of vulnerable patients and had a system in place which flagged their vulnerability in their individual records. Two GPs at the practice provided specialist support for patients with mental health conditions. GPs told us they held weekly mental health clinics and drug and alcohol recovery clinics but often met the needs of these patients outside these clinic times.

The practice building was accessible to patients. The practice operated from the newly purpose built medical centre which had opened at the end of 2012. GPs told us the building had been designed to meet the requirements of disabled patients and patients with special needs. The practice operated over three floors with lift access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Information leaflets for health promotion were available for patients to take away with them should they wish to do so.

Listening and learning from concerns and complaints

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

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions that had been taken to resolve each complaint as far as possible. We saw copies of staff meeting minutes where complaints had been discussed. Staff confirmed that complaints were discussed during their meetings.

We tracked three complaints and found these had been handled in a timely way with learning identified where appropriate. For example, we saw where a complaint had been made by a patient who had waited a considerable length of time for their appointment, to find that their name had not been added to the correct appointment list. On investigation it was found this had been due to a computer error at the time of arrival at reception. The practice reviewed their procedures and had enlarged the notice in the waiting room which asked patients to contact reception in the event they had waited longer than 20 minutes for their appointment.

Patients told us they were aware of the complaints procedure should they need to make a complaint, although we were told no complaints had been necessary. Staff we spoke with knew how to access and support patients with the complaints procedure. They knew to refer any complaints received to the complaints lead.

We saw that 18 complaints had been logged for the previous 12 months. These had included complaints made verbally, by e-mail, phone calls, letters as well as those where complaint forms had been completed. This showed that patients knew how to complain and all complaints were looked and actioned however serious or otherwise they were. Accessible information was provided to help patients understand the complaints system on the practice's website, posters displayed in the waiting room and in the reception area.

We saw that compliments received by practice had been kept. For example, we saw a comment from a patient who had suffered mental health problems. They had appreciated the support the practice had given them when they felt there was no one else there for them. Another patient commented that they had really appreciated the support they had received from the practice over the years they were registered with them.

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 aim of the practice was to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. GPs spoken with confirmed this. The practice also believed to be effective that it was important to ensure that all members of their workforce team were happy in their work, were supported and were committed to achieve high quality services for patients. We spoke with nine members of staff and they all demonstrated they understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through training and through appraisals. We spoke with GPs who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and practice managers were very supportive.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at seven of these policies and procedures. All seven policies and procedures we looked at had been reviewed annually and were up to date. Staff confirmed they had read the policies and procedures and knew how to access them should the need arise.

Named members of staff had lead roles. For example, the senior partner was the lead for complaints and chronic heart disease, while other GPs were the leads for safeguarding adults and children, end of life care and training. The practice manager was the Caldicott Guardian. Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with nine members of staff and they were all clear about their own roles and responsibilities.

The practice held a meeting of clinical staff every two weeks which staff told us included discussions about any significant events (SEs) that had occurred. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEs. This helped to make sure that learning was shared with appropriate members of the team. We saw that minutes of meetings had been kept to confirm these discussions had taken place. We found however that the minutes listed the topic headings but had not recorded details of the discussions, the learning identified and the outcome of these discussions. There was no clear audit trail to evidence decision making processes to confirm the learning that staff told us had taken place.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. 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. We found that QOF data monitoring was focussed and organised and provided detailed evidence that showed actions taken and planned by the practice to improve or maintain their QOF targets.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place with responsibility for different areas shared amongst partners. There were two managers, one with clinical and one with administrative responsibility. The staff were organised into medical, nursing and reception teams. These operated as separate teams that were linked by managerial input.

Staff felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt all of the partners were approachable. Staff also confirmed that the practice manager had an open door policy. Staff we spoke with told us that the practice was a caring and a good place to work. We found from observations and talking with staff that morale at the practice was high.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy, recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

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

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. The PPG made sure that patients' views were shared with the practice and used to shaped practice development. The PPG met at least four times per year. The group was attended by eight regular members, the practice manager and a GP. A medical secretary also attended to support and facilitate the group agendas, minutes and meetings. The practice Virtual Patient Participation Group (VPPG) was set up in July 2011 to increase the number of patients involved from different population groups. A VPPG enables patients to participate in surveys and share their views by email and through the practice website without the commitment to attend meetings. While the VPPG was considered by the practice to be in the early development stages, over 250 patients had been emailed to seek their opinion about the practice.

We saw the results of the survey carried out in 2014 to gather views of patients registered with the practice. Patients were given a questionnaire to complete when they attended the surgery in January and February 2014. The patients were chosen at random by the reception staff as the patients booked in for their appointment. All responses were anonymous and were collected in a patient questionnaire box. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The report showed that the majority of patients were happy with the service provided by the practice. The action plan identified that clarity was needed with regard to the test results system, to ensure that patients understood contact arrangements dependent upon the nature of the results. The results and actions agreed from these surveys were made available on the practice website.

Staff told us the practice shared the results of surveys with the whole team for discussion at staff meetings. We saw minutes of meetings that confirmed that topics had been discussed although the details of the discussions had not been fully recorded in all instances. Staff told us they were given the opportunity to give feedback on any of the findings from the survey report. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon.

In addition to meetings the practice gathered feedback from staff through appraisals and discussions. Staff told us they felt able to provide feedback and discuss any concerns or issues they had with any of the management team at the practice. Clinical, reception and administrative staff told us they felt involved and fully engaged with the practice to improve outcomes for both staff and patients. We saw feedback from medical students at the University of Birmingham who had worked on placement at the practice. They commented that all staff, especially the reception staff were very warm and welcoming.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed they knew who to talk with in the event they had any concerns.

Management lead through learning and improvement

The practice held various team meetings that ensured continued learning and improvements for all staff. We saw minutes of administrative and reception staff meetings and management team meetings that showed discussions had taken place on a range of topics. Through discussion with the GPs and staff we found they clearly understood about safety and the importance of learning from incidents. We saw minutes of meetings that showed concerns, near misses and significant events (SEs) had been discussed. We found however, that detailed minutes that recorded the learning and discussion about these were inconsistent. The minutes we saw contained topic headings with minimal detail to support these. We found there was no formal record to evidence that the discussions provided a clear audit trail of action, learning and outcomes of these. The practice manager and registered manager told us they were aware that they needed to formalise and improve the way minutes of all meetings were recorded. They confirmed that they had started to work on a formal template to help with this process.

Are services well-led?

Good

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

The practice had also developed guidance and systems for reception staff on how to carry out particular tasks, such as in the use of the computer and a reception handover folder. Staff told us they were involved in compiling these and found that this had helped to improve and develop their skills.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals had taken place which had also included 360 degree feedback (a system or process in which employees receive confidential, anonymous feedback from the people they work with). Staff told us that the practice was very supportive of training and that staff were able to request particular courses to support their development.

The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP registrar. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team. Two GPs provided training for medical students who attended the practice on placements from Birmingham University. They commented on feedback forms that the practice was a good learning environment.