Drs Ashcroft, John Dingle and Dingle

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Drs Ashcroft, John Dingle and Dingle (also known as Landscape Surgery) on the 14 October 2014.

We inspected this surgery as part of our new focused, comprehensive, inspection programme. This practice had not been inspected before. We looked at how well the practice provided services for specific groups of patients. These included; older patients, patients with long-term conditions, families, children and young people, working age patients (including those recently retired and students), patients living in vulnerable circumstances and patients experiencing poor mental health (including people with dementia). The overall rating for this practice was good.

Our key findings were as follows:

- There was a clear management structure to support and guide staff to deliver safe, responsive and effective care to patients.
- We found that the leadership team was very visible. There were good governance and risk management measures in place.
- Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The surgery took time to listen to the views of their patients and ran an active Patient Participation Group and any actions identified were implemented and used to improve the service.

We saw several areas of outstanding practice including:

- One of the GPs co -developed and invented an IT software system which allowed GP's to seek advice via a secure electronic communications system for secondary care consultants. This was a Clinical Commissioning Group led initiative. The surgery played a key role in testing the software and piloting the system.The system facilitated timely patient referrals to a number of specialities within the local

Summary of findings

NHS Trust. These included: Haematology, Gastroenterology, Cardiology, Respiratory Medicine, Diabetes, Endocrine services, Oncology, Rheumatology and latterly palliative care.

- The practice community dispensary and pharmacy completed audits on how long it took to dispense patient's medicines for the patient's convenience and on reducing the number of medicine owing's so patients did not have to return to the dispensary more times than necessary. Timely medicine deliveries to patients in the local community and patients who lived in nursing care homes.
- Staff worked with the community long term conditions team who helped with ensuring appropriate pre-screening counselling could take place for vulnerable patients who required regular screening. Patients with mild to moderate mental health problems were supported further by referral from the GP to their in-house counsellor.

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

- Nurse staff training was not always in line with the practices' own policies.
- The recruitment policy did not include all the information as specified in Schedule 3 of the Health and Social Care Act (2008) for the purposes of carrying on a regulated activity, and record such other information as is appropriate.

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 safe.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents. Lessons were learned and communicated widely to all staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for effective.

Multidisciplinary working was evidenced as demonstrated in the minutes of meetings held, working with the palliative care and community heart failure service as well as the falls team. The practice engaged with the Clinical Commissioning Group (CCG) and with local initiatives and strategies to improve the health and well-being of their patients.

The practice set up the Advice and Guidance system, to discuss patient referrals with secondary care specialists and reduce the numbers of unnecessary referrals by sourcing appropriate alternative treatment, care or support appropriately. We were informed that this has been taken up by the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Communication with the community health and social care teams was robust and fostered the co-ordination of individual patient focused treatment and care. Staff routinely utilised best practice guidance such as National Institute for Health and Care Excellence (NICE) care pathways. Patient'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.

The surgery completed appraisals and encouraged role appropriate staff development.

The dispensary was effective in meeting the needs of the patients and local community in a timely manner. The community matron reported the dispensary and pharmacy to be exceptionally effective in meeting the needs of the patients and local community such as the nursing and residential care homes.

Summary of findings

The GPs held short, daily referral peer review meetings and discussed all potential referrals from the preceding 24 hours. They also used the meeting as a point of learning to discuss uncertain or difficult cases. They found that the results of the process showed a marked impact on reducing the number of proposed referrals to secondary care outpatients, by peers discussing alternative ways of managing patient investigations. This reduced the need for patients to attend secondary care facilities unnecessarily.

Are services caring?

Good

The practice is rated as good for caring.

All 43 CQC comment cards received and the patients we spoke with commented positively on the surgery, the kindness of the staff and treatment received. NHS England's GP Patient Survey July 2014 found that 95% of respondents would recommend this practice to someone new to the area. NHS England's GP Patient Survey July 2014 found that 95% of respondents would recommend this practice to someone new to the area.

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 ensured confidentiality was maintained. The design of the surgery and staff team locations enabled patient privacy when booking appointments.

Staff worked with the community long term conditions team who helped with ensuring appropriate pre-screening counselling could take place for vulnerable patients who required regular screening.

The practice always offered longer appointment times for patients with a learning disability or mental health needs, to ensure patients were given time to be fully involved in making decisions about their health. All patients spoken with and comment cards reported that patients from all groups did not feel rushed during their consultation.

Patients with mild to moderate mental health problems were supported further on referral from the GP to their house counsellor.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements, where these were identified. Patients reported good access to the surgery. There were good facilities and

Summary of findings

they were well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that they responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for well-led.

There was a clear strategic vision in respect of staff roles, responsibilities, staff succession planning, career progression, education and training in order to deliver and further develop the service. Staff were clear about their responsibilities and a clear leadership structure was in place. Staff felt supported by management and all staff spoke of their appreciation of each other's roles and their sense of team. There were systems in place to monitor and improve quality and identify risk. The service proactively sought feedback from patients and this was acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Outstanding ☆

Older people

The practice was knowledgeable about the number and health needs of older patients using the service. They actively reviewed the care and treatment needs of older people. Patients over the age of 75 had a named GP.

An up to date register of patients' health conditions, carers' information and whether patients were unable to attend the practice due to their frailty. They used this information to provide services in the most appropriate way and in a timely manner. A small percentage, 0.67 %, of patients registered at the practice lived in nursing homes and the GPs visited their patients at the nursing homes.

We heard from patients in this age group and were informed that the telephone consultation (triage) was very accessible and staff knew and remembered them. Patients informed us that they found the practice staff enquired as to their family support and networks if they lived alone. They found that staff were interested in them and their families and maintained a real interest in them as older people in their local community. They encouraged them to attend various health and social care groups' particular to their needs for example referring to a local gym for exercise classes.

Public Health England data found that male life expectancy at the surgery was 79.8 years and female life expectancy, 82.5 which compared favourably when reviewing the CCG area figures of 77.5 and 82.0 for females. In comparison the England average is 78.9 for males and 82.9 for females.

We saw the practice monitored the over 65s' flu vaccination uptake rate which we saw was 78% and that the 70 and 79 shingles uptake vaccination rate was 81%.

Staff at the practice referred where appropriate patients to the falls team, to exercise classes, and provided literature and health promotion leaflets specifically designed to inform and assist older patients, such as Age Concern. The Community Matron saw patients who were unable to attend the practice which included older patients and met the GPs on a regular basis to discuss new and current cases.

The GPs held short, daily referral peer review meetings and discussed all potential referrals from the preceding 24 hours. They also used the meeting as a point of learning to discuss uncertain or difficult cases, which included older patients. They found that the

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results of the process showed a marked impact on reducing the number of proposed referrals to secondary care outpatients by peers discussing alternative ways of managing patient investigations. This reduced the need for patients to attend secondary care facilities unnecessarily.

People with long term conditions

Outstanding 

Staff had a very good understanding of the care and treatment needs of people with long-term conditions (LTC). They monitored the needs of this patient group and promoted ways the patient could improve their quality of life. We heard from these patients that staff invited them for routine checks and reminded them of appointments at the clinics. Public Health England data showed that 58% of patients registered at the practice had a long-standing health condition.

We found staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was consistently followed.

The practice had a complete register available of all patients in need of palliative care and support irrespective of age. They held monthly multidisciplinary case review meetings where all patients on the palliative care register were discussed.

The GPs held short, daily referral peer review meetings and discussed all potential referrals from the preceding 24 hours. They also used the meeting as a point of learning to discuss uncertain or difficult cases, which included those patients with long term conditions. They found that the results of the process showed a marked impact on reducing the number of proposed referrals to secondary care outpatients by peers discussing alternative ways of managing patient investigations. This reduced the need for patients to attend secondary care facilities unnecessarily.

The Community Matron saw patients with LTC who were unable to attend the practice and met the GPs on a regular basis to discuss new and current cases. Polypharmacy medicine reviews (patients on multiple medications) were done annually around the patients birth dates. For example epileptic patients had a yearly review to discuss their medication as well as their health check, to see how well controlled they were and searches were carried out each month to ensure this had occurred.

Each GP had a lead for a different long term medical conditions. They were responsible for ensuring that they updated the practice

policies for disease management accordingly, for example the recently updated hypertension policy following NICE guidance. GPs referred patients with heart failure to the community based heart failure clinic.

Staff worked with the community long term conditions team who helped with ensuring appropriate pre-screening counselling could take place for vulnerable patients who required regular screening.

Families, children and young people

Good

The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

All of the staff were very responsive to parents' concerns and ensured parents could readily bring children into the practice to be seen who appeared unwell.

We saw that the practice monitored their cervical screening for young people from 25 years old as well as the pregnant mothers' uptake of the flu vaccination. Chlamydia screening was organised at the schools and colleges in general but could also be arranged at the practice.

We saw that the practice were aware that any teenage pregnancy patients could be supported by a teenage specialist midwife to provide age appropriate support and advice.

The practice operated a walk in family planning and sexual health clinic each Tuesday.

Child development clinics were held at the practice each week and the GPs completed the eight week checks. Practice nursing staff performed the immunisations. They worked closely with families at risk as identified by the Health Visitor.

Working age people (including those recently retired and students)

Good

The practice provided a range of services for patients to consult with GPs, a triage nurse and nurses, including on-line booking and telephone consultations.

The practice had developed an information database which covered the needs of their entire patient group. Staff had a programme in

place to monitor if patients missed their regular reviews for their conditions such as diabetes, respiratory and cardiovascular problems. Public Health England data showed that 58.6% of patients were either in paid work or full-time education.

The practice website and staff provided self-help advice and health promotion education opportunistically at nurse clinics and GP appointments as well as having literature available. GP appointments were available 8.30am to 5pm with emergency same day appointments either side of these appointments 8am-6pm. The Nurse Practitioner had appointment slots for both face to face consultation and via telephone. Appointments with the phlebotomist (blood taking) were from 8am.

The practice completed bowel cancer screening for those patients assessed as being at risk over 60 years old and Cardiovascular disease (CVD) risk assessments for patients aged 40-74 years.

People whose circumstances may make them vulnerable

Good

The practice made adjustments to how they provided the service in order to meet patients' needs. For example, the practice offered longer appointment times for patients with a learning disability or mental health needs. This helped to ensure patients were given time to be fully involved in making decisions about their health. Notes on their computer system identified patients with any specific or special needs for staff awareness. The community long term conditions team helped with ensuring appropriate pre-screening counselling could take place for patients who required regular screening. Staff said routine blood tests in most instances were arranged at least one week in advance of health checks.

The practice were aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks.

Staff were knowledgeable about safeguarding vulnerable adults and children. Care plans were in place for all vulnerable patients. The Care plans were not held on their systems as there was an IT problem which they were working on, but were available for the GPs to view.

Homeless patients and travellers could register at the practice.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. We saw that 88% of these patients had an agreed care plan in place.

The GPs proactively ensured they were up to date with the latest developments for patients with mental health needs. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision. They had referral access to their in house counsellor and could also refer to the Child and Adolescent Mental Health Services (CAMHS) designed for children aged 0-18 and their families who are experiencing mental health problems.

All of the staff had a very good understanding of patients' social background, conditions and personal attitude towards their health. They used this information when taking calls and talking to patients.

We saw literature was available for patients for bereavement counselling and support.

GPs informed us that where appropriate, they could refer patients to the memory clinic.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our visit and received 43 Care Quality Commission comment cards. We spoke with male and female patients, carers, working age patients and mothers with children. All patients were very complimentary about the care provided by the clinical staff and the positive and friendly atmosphere fostered by all staff. They found the doctors, nurses and dispensary staff to be professional and knowledgeable about their treatment and care needs. Patients reported that the whole staff team treated them with dignity and respect.

The practice had a patient participation group who met regularly with the GPs and senior staff. They informed us that the meetings were productive and effective, their views were listened to and where appropriate acted upon in a timely manner. They raised no concerns about the practice and informed us they found them to be responsive to local patient's needs. They expressed that the staff were professional, approachable, and compassionate and the staff treated patients as individuals, with dignity and respect.

The National GP patient survey results for Drs Ashcroft, John Dingle and Dingle published in July 2014 forwarded 250 surveys and 133 were returned, which gave a 53% completion rate. The survey results found that 89% of patients found it easy to get through to the practice by phone (decreased by 0.4% on the previous year). 95% of patients would recommend the practice to someone new to the area (increased from previous year). 80% of patients usually waited 15 minutes or less after their appointment time to be seen and 91% described their overall experience of the practice as good (increased by 0.4%).

Areas for improvement

Action the service SHOULD take to improve

Nurse staff training was not always in line with the practices' own policies.

The recruitment policy did not include all the information as specified in Schedule 3 of the Health and Social Care Act (2008) for the purposes of carrying on a regulated activity, and record such other information as is appropriate.

Outstanding practice

One of the GPs co -developed and invented an IT software system which allows GP's to seek advice via a secure electronic communications system for secondary care consultants. This was a CCG led initiative. The surgery played a key role in testing the software and piloting the system. This system facilitated timely access referrals to a limited number of specialities within the local NHS Trust. These included: Haematology, Gastroenterology, Cardiology, Respiratory Medicine, Diabetes, Endocrine services, Oncology, Rheumatology and latterly palliative care.

The practice community dispensary had completed audits on how long it took to dispense patient's medicines for the patient's convenience and in reducing the number of medicine owing's so patients did not have to return to the dispensary more times than necessary. As well as ensuring timely medicine deliveries to patients in the local community and patients who lived in nursing care homes.

Staff worked with the community long term conditions team who helped with ensuring appropriate pre-screening counselling could take place for vulnerable patients who required regular screening.

Patients with mild to moderate mental health problems were supported further by referral from the GP to their in-house counsellor.

Drs Ashcroft, John Dingle and Dingle

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, included a GP specialist advisor and a specialist advisor with a background in practice management.

Background to Drs Ashcroft, John Dingle and Dingle

Drs Ashcroft John Dingle and Dingle provides a weekday service for 7,008 patients (based on the practice figures on 07 October 2014) in the North Lancashire area and is part of NHS Lancashire North Clinical Commissioning Group.

Public Health England figures show that 36% of all patients at the surgery are 65 years of age or over and the largest percentage of the surgery population, 58.6%, are of working status either paid work or in full-time education.

The practice opens Monday to Friday from 8am to 6pm each weekday with the exception of Thursday when it closes at 1pm. They operate an all-day telephone consultation (triage) service for urgent appointments led by the Nurse Practitioner. When the practice is closed and during the out of hours (OOH) periods patients are requested to contact either the ambulance service for emergencies or telephone the 111 service. The OOH service is provided by Preston Urgent Care Centre.

The practice has four GP partners, two male and two female, and employ a salaried GP, one Nurse Practitioner (NP), Practice Nurses, and a phlebotomist. The staff team includes a pharmacy technician and dispensing staff. The practice has a practice manager and deputy practice manager and all are supported by administration, reception and secretarial staff. They are a GP training practice.

The dispensary is shared between the two GP practices co-located at the medical centre in order to meet the needs of their patients. This is also a pharmacy set up to help extend services to their patients and local community.

The practice use the same locum GP, when required, for continuity of service and support for their patients. The GP partners who work at the practice have their professional details available for patients to read on the surgery website as well as their specialist interests. Clinics run by the practice include amongst others; child development, minor surgery, long term condition management which includes a wide range of conditions, for example; diabetes, heart disease and hypertension (high blood pressure) and travel clinics.

Why we carried out this inspection

We inspected this surgery as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the surgery and asked other organisations to share what they knew. We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We reviewed 43 CQC comment cards where patients shared their views and experiences of the service.

We saw that staff appropriately managed patient information received from the out of hour's team and patients ringing the service. We saw the ordering of repeat prescriptions, how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the surgery to run the service.

Good

Are services safe?

Our findings

Safe Track Record

Information from NHS England and NHS North Lancashire Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. We reviewed policy records and found that some policies had dates for review whilst others were undated; it is best practice to review policies regularly or amend as soon as a change in either policy or legislation occurs. We saw that all staff had been trained to at least a minimum level of basic life support.

In the period between November 2013 and September 2014 there had been nine reported significant events, there were no identified themes or patterns to these events. These included clinical and non-clinical issues. We saw that each incident had been analysed to consider what had occurred and why, what lessons had been learnt and where appropriate measures had been put in place to prevent future recurrence or improve care.

There were mechanisms in place using multiple information sources to ensure a shared awareness of key risks with all staff, for example they had systems to promptly manage national patient safety alerts in order to protect patients.

We saw that that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks.

The dispensary completed clinical and administration audits on a regular basis, we saw and staff informed us that staff implemented any learning from them. As an example we saw evidence of how the dispensary completed records with any noted near misses.

Learning and improvement from safety incidents

We found that staff actively reported any incidents and viewed this process as a positive way to ensure they provided a high standard of patient care.

We found that with any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed at staff meetings and staff received emailed updates. Staff met on a regular basis and those who attended the meetings confirmed the value and effectiveness of the meetings. This information sharing meant the GPs, nurses and non-clinical staff were confident that the treatment approaches adopted followed best practice.

The majority of these meetings were minuted. Minutes which outlined the content of the meetings improve governance mechanisms and minimise the potential of staff misinformation or error.

Reliable safety systems and processes including safeguarding

We saw evidence that health and safety was managed effectively within the surgery. We saw that staff were aware of health and safety issues. For example: needle-stick injury protocols and instruction on the location of equipment for use in emergencies and emergency fire procedures.

We saw evidence that the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. All staff completed training on fire safety as part of their induction with further annual reviews. Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency. Alerts could also be raised using the computer system.

There were procedures in place for managing and dealing with safeguarding children and adults and staff could access the local authority's safeguarding policy and procedures. A named GP took the lead role in safeguarding adults and children. Staff had received training in safeguarding but the majority of nursing staff had completed this training in 2011. The practice manager demonstrated that further training in vulnerable adults and children's safeguarding was booked. They were aware of the appropriate training level requirements for their staff for example that GPs attain Level 3 and nurses at least Level 2. Staff had a good understanding of safeguarding and told us how information would be recorded on patient notes if a safeguarding concern was raised.

The practice manager informed us that the GPs would attend any meeting requests from the local authority safeguarding board and local multi-disciplinary meetings where able to do so. The GP safeguarding lead informed us that in the last 12 months they had no cause to attend a safeguarding board meeting.

Good

Are services safe?

Staff understood what was meant by the term "Whistleblowing" and the practice had a policy in place. This meant there were processes in place to assist staff to expose poor care or poor practice by others such as colleagues, if any were apparent.

Medicines Management

The practice dispensary was part of the Kepple Lane pharmacy and dispensary based at the medical centre. Kepple Lane pharmacy was registered as Garstang Medical Services Limited. The pharmacy and dispensary employed a total of 24 staff excluding the pharmacist. There was a clear staff responsibility sheet in place for the Dispensary Services Quality Scheme (DSQS). There were six qualified pharmacy technicians with Accuracy Checking Technician (ACT) qualifications from the National Pharmacy Association (NPA) and Over the Counter (OTC) qualifications. Nine members of staff held an NVQ Level 2 in Pharmacy Services and 11 staff held OTC qualifications. Other staff members were working towards various relevant qualifications.

Although based in the practice governance arrangements were reflective of Kepple Lane pharmacy. There was a risk management protocol in place for the dispensing services in addition to other risk management protocols at the practice. We saw that there was a copy of the dispensary risk policy in place.

Kepple Lane pharmacy and dispensary had its own patient and customer information leaflet which included information on how to make a complaint or suggestion which was in line with best practice. There was a named complaints manager responsible for the dispensary.

A repeat prescribing policy was in place and was reviewed in September 2014. The surgery regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. We saw there were 46% of patients on repeat medications and that 76% of patients had been in receipt of a medication review. Medication reviews were conducted by GPs, the practice pharmacist and the nurse practitioner. In general, apart from exceptional circumstances, the remainder were invited to attend the surgery prior to the next prescription being issued.

Security measures were in place for prescriptions access. When making home visits, GPs took suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads were carried in a locked carrying case and not left on view in a vehicle. However, not all GPs recorded prescriptions serial number data, as suggested best practice, NHS Protect Security of prescription forms guidance, August 2013. The GP assured us that this would be implemented. We were told that the GPs rarely took paper prescriptions to visits and in general used the electronic prescription service as they found this to be safe practice as many patients were on multiple medications.

The dispensary had a controlled drugs register in place (this is for medicines which require extra administration checks to ensure safety) and regular audits of the controlled drugs took place. These were stored appropriately in locked metal cabinets with controlled access by the authorised key holder only there was also a security camera in place. The dispensary standard operating procedures included the safe disposal of medicines and appropriate record keeping such as the destruction of any controlled drugs (denaturing).

The medicines fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. There were clear cold chain protocols in place. The cold chain is the system of transporting and storing vaccines within the safe temperature range of 2°C- 8°C.

Oxygen was stored appropriately and ready for use.

The dispensary staff had conducted audits including a pharmacy patient questionnaire in 2013-2014. As an example of the responses received 85% of patients were very satisfied and a further 10% were fairly satisfied with the time they had to wait for their prescription to be dispensed. They also conducted an 'Owings Audit'; this audit was carried out over a six month period from May to October 2013. The audit measured the percentage of patients who did not receive all their required medications at the first attempt to dispense and had to return at a later time for the remainder of their medicine. The audit also broke down the items into unavoidable and potentially avoidable owing's. The aim was to identify the reasons causing the owing's to occur and identify any steps that could be taken in order to reduce the number of items owed to patients. The results demonstrated that that there was a small amount of unavoidable owing's per month dependant of numbers of prescriptions submitted ranged between 0.13-0.20%.

Good

Are services safe?

The community matron reported they found the dispensary and pharmacy to be exceptionally responsive and effective in meeting the needs of the patients and local community such as the nursing and residential care homes.

Cleanliness & Infection Control

Clinical staff were responsible for ensuring infection prevention and control standards were maintained between patient appointments. The surgery had an infection prevention and control policy in place. A nursing member of staff was appointed lead in relation to particular aspects of infection prevention and control. Systems were in place whereby spot checks were carried out to ensure protocols were followed. The nurse had completed a six month infection control audit and had submitted this to the practice manager we were informed that any areas identified for improvement would be actioned.

We saw that supplies of personal protective equipment were available, for example, disposable gloves. There were appropriately labelled sharps boxes in consultation and treatment rooms for disposal of used needles. These were stored out of reach of children. Throughout the practice we saw hand wash sinks with hand sanitizer gels available and guidance on hand wash procedures. Protective and single use clinical equipment were stored appropriately.

The practice had contractual arrangements with a registered external provider for weekly collection and disposal of clinical waste. There was no build-up of waste awaiting collection and the arrangements appeared adequate and timely to meet their needs. Contract cleaners were employed to attend on a daily basis.

Equipment

There was a contract in place to ensure that medical equipment was calibrated to ensure it was in working order. The practice also had contracts in place for portable appliance tests (PAT) to be completed on an annual basis. The building maintenance contracts were appropriately held and appropriately updated.

The practice had a defibrillator which ensured they could respond appropriately if a patient experienced a cardiac arrest. Emergency equipment including oxygen was readily available for use in the event of a medical emergency. This equipment was regularly checked by the nursing staff.

A blood pressure monitor was available in reception for patients use. Patients were encouraged to present the result of this to the reception team who forwarded the results to the nurse for analysis and follow up.

The business continuity plan was updated in 2014 and included contact details in the events of supplier failure and information about their essential equipment suppliers.

Staffing & Recruitment

The practice had a recruitment policy in place and employed 22 staff including the GP partners but excluding the dispensary staff. We looked at the recruitment files of five members of staff. The sample included clinical and non-clinical staff. We noted there was not always proof of identity on staff files. There was not always evidence to show qualifications claimed had been verified. The practice manager explained these checks had been completed but no records maintained. They assured us this would be addressed in future. The records of the most recently recruited staff included relevant checks such as references, as well as criminal record checks by the Disclosure and Barring Service.

The practice manager told us that if a locum GP joined the practice on temporary basis they would make checks to ensure their registration with the GMC was valid and checked NHS England's performers list.

The practice manager informed us that nursing staff copied them into their Nursing and Midwifery Council (NMC) registration updates. There were no formal systems in place to ensure that permanent clinical staff continued to hold valid registrations with their respective professional bodies. The practice manager assured us processes would be put in place to address this in future. The GPs were checked against the NHS performers list and General Medical Council (GMC) and all were registered with license to practice.

Monitoring Safety & Responding to Risk

The practice manager told us that staff would be notified by email of any actions requiring immediate implementation to ensure they were addressed in a timely manner. Learning for example from significant events was then further discussed at scheduled staff meetings to reinforce messages and ensure actions had been completed. Staff confirmed this process.

Good

Are services safe?

There was little staff turnover at the practice. We saw evidence that the practice tried to plan ahead for succession if a vacancy was anticipated to minimise any impact upon the service. The practice team had agreed the requirements for safe staffing levels and staff worked, in general, regular sessions or agreed set hours and set days each week to consistently maintain the service provided.

There was a workforce contingency plan for annual leave and sickness in place, such as locum GP cover. They demonstrated that their workforce planning was planned in advance where able to minimise the disruption to the service provided to their patients and ensure there was a period of 'handover' between staff. Reception staff were supported and received training to enable them to carry out a number of duties. The mix of skills meant the surgery had the flexibility to meet unexpected absence. The rotas we reviewed showed that sufficient GPs were on duty to cover appointments.

Staff took lead roles, for example in infection control and safeguarding adults and children. If any findings identified emerging risks these were fed back to staff so action could be taken to improve service delivery.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan last updated September 2014 in place to deal with emergencies that might interrupt the smooth running of the service, such as power cuts, telephone issues and adverse weather conditions. Staff knew what to do in event of an emergency evacuation and staff were aware of which staff member was the fire marshal on the day of the visit and who was responsible for health and safety.

We found all staff were trained to a minimum of basic life support to support patients who had an emergency care need. All emergency equipment was regularly checked and readily available for staff to access in an emergency. We saw that the surgery had the 2010 Resuscitation Guidelines in place which were the most current. The practice had awareness of the Resuscitation Council (UK) Equipment and drug lists guidance for cardiopulmonary resuscitation in Primary Care published November 2013.

We saw that adult pulse oximeters were available for staff to use. These assist staff in monitoring patient's oxygen saturation levels. The nurse practitioner informed us they were aware they needed to obtain a pulse oximeter child probe. Staff received regular basic life support training and training associated with the treatment of anaphylaxis, shock.

GPs bags were held in the dispensary. The GP signed to say when they took the bag out and there was a list of contents within the bag. If items were used during visits, the pharmacy were responsible for replenishing the items and for the stock controls in place. Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency. Alerts could also be raised using the surgery computer system.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided a service for all age groups. They maintained up to date disease registers for patients with long term conditions such as asthma and chronic heart disease and staff completed annual health reviews. They also provided reviews for patients on long term medication, for example for mental health conditions. We saw that 93% of patients with learning disabilities attended for review within a 12 month period. 88% of the patients on the practice mental health register had an agreed care plan in place. We discussed what happened when patients did not attend for review. The staff told us that letters were sent to remind patients and where appropriate the GP made contact with them.

The practice held child development clinics each week and GPs completed the six week checks. The nursing staff team performed the childhood immunisations and vaccination and followed up on patients who did not arrive for their appointments. We were told that for teenage pregnancy support there was a specialist midwife in place specifically to meet the teenager's needs.

We saw that an audit of cryotherapy treatments was completed by one of the GPs between August and September 2013. The term 'cryotherapy' means 'treatment using low temperature', and refers to the removal of skin lesions, such as warts, ordinarily, by freezing them. The findings concluded that there were no documented re attendances for adverse reactions such as infection, or damage to underlying skin and tissue, demonstrating safe practice.

Clinical staff told us how they accessed best practice guidelines to inform their practice and clinical staff met regularly to share such updates. The practice was a training practice and had a specific library area which encouraged learning within all staff groups.

Management, monitoring and improving outcomes for people

We saw that a variety of clinical audits had been completed and the findings disseminated to all staff. A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change.

An audit of their 'Advice and Guidance' system usage was completed in 2013-2014, which had been introduced across the local CCG. This system facilitated timely referrals to a number of specialities within the local NHS Trust. These included: Haematology, Gastroenterology, Cardiology, Respiratory Medicine, Diabetes, Endocrine services, Oncology, Rheumatology and latterly palliative care. They examined the impact of the advice requests in respect of how clinical cases were subsequently managed. The findings were all specialities with the exception of palliative care were used and a reduction in planned out patient referrals of 50% was seen. They found the system and pilot had been useful and had brought primary and secondary care closer together in the approach to patient's treatment and care. Their report on reducing avoidable outpatient activity demonstrated an on-going reduction in referrals of 19%. The GPs held short, daily referral peer review meetings and discussed all potential referrals from the preceding 24hours. They also use the meeting as a point of learning to discuss uncertain or difficult cases. They found that the results of the process showed a marked impact on reducing the number of proposed referrals to secondary care outpatients by peers discussing alternative ways of managing patient investigations.

A monthly palliative care meeting took place attended by members of the multi-disciplinary team and included for example; the GP Lead in palliative care, practice nurse, community matron, representatives from two nursing homes, nurse specialist at Trinity Hospice and representatives from the outreach team at the local hospice. The practice used specific templates to record palliative care management prompting staff to ensure every appropriate action has been undertaken, for example informing the out of hours service of palliative care patients. During the audits they considered what worked well, less well, what would have worked better and with improvements what will be different.

A Methotrexate audit was undertaken to ensure that all patients had necessary checks before starting treatment. Methotrexate is known as a disease-modifying drug and is used to treat conditions where a kind of 'over-activity' in the body is causing problems, for example rheumatoid arthritis, psoriatic arthritis and vasculitis. The findings were that the surgery had excellent compliance with the National Institute for Heath and Care Excellence (NICE)

recommendations. The main reason for patient's non-compliance was that patients did not attend for their blood test checks, and the action plan in place was to provide further individual patient education.

Effective staffing

A good skill mix was noted amongst the doctors and nurses and the nurse practitioners with qualifications to allow them to prescribe medicines.

The practice had appropriate policies and procedures in place to support staff in carrying out their work. An induction programme included time to read their policies and procedures. Staff, including trainee doctors, and locum GPs had easy access to a range of policies and procedures via the computers systems to support them in their work. We were shown the staff induction package which was in-depth and covered all aspects of the service.

All staff group's refresher training should be in line with staffs' professional body requirements as well as local and mandatory requirements. We saw that the nurse training in Infection Prevention and Control and adult and child protection required updating. The practice manager demonstrated that safeguard training had been booked. Nursing staff had not received formal training in the Mental Capacity Act (2005) and "best interests" decisions, but could locate appropriate support and guidance.

Clinical staff took responsibility to maintain their appropriate professional refresher training in a timely manner; this included the training expectations in line with national guidance as well as those of the local Clinical Commissioning Group (CCG). A training policy was in place and training included in-house training, external training courses and on-line in the form of E-Learning. The mandatory training included for example annual fire safety and confidentiality. The practice manager maintained a training log for all staff other than the GPs.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on NHS England performers list). GPs had appropriate indemnity insurance coverage in place as did the nursing staff. All staff had annual appraisals to review performance at work and identify learning and development needs for the coming year.

Although no formalised staff supervision was recorded staff felt they received appropriate support and used their regular meetings as group support. Nursing, reception and dispensing staff told us they worked well as a team, all enjoyed working at the surgery and felt their strength was that they worked as a team and had good access to support from each other.

There was a range of staff meetings to support staff, as a form of effective communication, provide learning opportunities and to case review. These included amongst others: monthly practice nurse meetings, monthly team representative meetings, reception team meetings, patient participation meetings quarterly, monthly palliative care meetings and daily GP referral review meetings.

Working with colleagues and other services

The practice worked with other health and social care providers to meet patient's needs. They worked with the local community nursing team, midwives, health visitors, and for patients with learning disabilities, the community disability team amongst others.

The practice held long term conditions team (LTC) meetings quarterly attended by the practice manager GPs, Community Matron (CM), and LTC patients were discussed at the monthly palliative care meetings. There was excellent communication between the CM, the community team such as district nurses and the surgery. All patients seen by the LTC team were identified on the patient's record. The LTC meetings ensured the GPs and surgery staff were aware of the patients with current major problems or concerns. As the community team was located in the same building this enabled efficient communication about patient's co-ordinated care.

It was clear that each GP had responsibility for the care of their patients and had allocated care homes which they attended regularly. Nursing home patients represented 0.67% of the practice patient list. We were told that their patients in nursing homes had a yearly medicines review with the practice pharmacist. GPs informed us that contact was made with the out of hours (OOH) provider to make sure there was a full exchange of information about any patients receiving palliative care.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Patients with a learning disability who had other health conditions when invited to the surgery for investigations, such as blood tests, were supported to become fully involved in their care and in making decisions. For example residential and care organisations staff supported patients when making appointments and attending the surgery. The Learning Disability Team (LDT) helped with appropriate pre-screening counselling and routine blood tests were arranged, where appropriate, at least one week in advance of any health checks.

It was clear the practice worked with other agencies such as Help Direct who provide a support and information service for adults that seek to assist patients with a wide range of issues. These might include for example assisting patients with mental health problems. The practice patients had access via referral to their in house counsellor, Child and Adolescent Mental Health Service (CAMHS) referrals were also made The practice manager told us that bereavement counselling could be provided at the local NHS Foundation Trust building.

The practice completed an audit and produced a plan to reduce avoidable accident and emergency attendances in 2012. The findings were that 83% of attendances were appropriate and of the remainder, 12.5% may have been avoided. The audit process led to them setting up GP educational meetings around A&E attendances. The GP's felt that patients who reside in Lancaster would attend accident and emergency or OOH's services rather than travelling to Preston to attend the Preston Primary Care Centre. This was suggested to be a practice geographical problem and ways into improve this required further discussion the outcome of which had not been specified. Audits of their Urgent Care Dashboard took place this included ensuring that patients had an allocated GP informed of any attendance at accident and emergency or OOH and take any action required using the Urgent Care Protocol. The outcome was that the GPs, pharmacist and administration staff meet to discuss the patients on the Urgent Care Dashboard to put a plan of action in place with the aim to reduce inappropriate attendance.

Information Sharing

Staff completed mandatory training based on their role and all staff attended equality and diversity and confidentiality training. We saw that the staff completed information governance training which included amongst others; records management and the NHS Code of Practice, access to health records, secure transfers of personal data and password management.

Access to patient information was dealt with in accordance with NHS guidelines. The practice followed the Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing takes place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent, unless there were exceptional circumstances as stated in the above mentioned Acts.

Staff were able to clearly explain the processes, checks and safeguards that took place for the safe transit of patient's paper and electronic records.

Information sharing took place appropriately, such as within multi-disciplinary team meetings, best interest decision meetings, safeguarding adults and children, advanced directives, palliative care meetings and shared care such as hospital referrals and discharges and community team involvements.

Consent to care and treatment

Nursing staff were aware of how to locate the surgery information which dealt with the Mental Capacity Act (MCA) 2005 and best interest decisions but had received no formal training. This legislation is a legal requirement that needs to be followed to ensure decisions made about patients who do not have capacity are made in their best interests. The practice manager assured us that they would look into the training available.

We found GPs were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice.

The nurse or GP sought consent and approval for treatments such as vaccinations from the child's legal guardian. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of the GPs practice and electronically recorded in the patient's record.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We saw and staff informed us they had access to interpreter translation services for patients who required the service.

Health Promotion & Prevention

All new patients were asked to complete a health questionnaire and offered a consultation. We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

Patients were encouraged by the practice to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

At the time of inspection the surgery was promoting flu immunisation. Patients saw the promotion literature and the practice put measures in place to ensure that the needs of the patients regarding flu immunisation could be met.

We saw that there was a range of health promotion information on display in the waiting area patients used. On the day of the visit information regarding Age Concern and the service it offered was provided on a health promotion board. In the reception area the surgery had a blood pressure monitoring machine available for patients to use and they were encouraged to feedback any results to the clinical staff. The GPs also referred patients to exercise classes through the local gym.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients spoke positively of their dealings with both clinical and non-clinical staff. We spoke with four patients on the day of our inspection they told us they were treated with dignity and respect; they said that practice and dispensary offered an excellent service and staff were kind, thoughtful and caring. Without exception the 43 CQC comment cards received and the patients we spoke with commented positively on the practice and the kindness of the staff. All were extremely complimentary about the care and treatment being provided. They found the doctors and nurses delivered a very personalised service and had an excellent understanding of their needs. NHS England's GP Patient Survey July 2014 found that 95% of respondents would recommend this practice to someone new to the area.

We saw staff speaking with patients attending the practice and heard them engaged in conversation with patients on the telephone. They followed the practice confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw that staff were friendly, polite and respectful in dealing with patients.

The reception staff dealt with incoming calls and made outgoing calls from a separate room to the reception front desk area. Therefore when patients contacted the practice they could be assured that their call was not inappropriately overheard. When patients approached the front desk reception area they could request to speak with the staff in a privately located room to the side of the reception. The reception desk area was also separated from the waiting room by a door again facilitating privacy where able to do so.

Consultation rooms had lockable doors and privacy curtains. We saw that doors were closed during patients' appointments. Notices were displayed in the reception area advising patients they could have a chaperone present during their consultation if they so wished. Staff were trained to act as chaperones.

Their computer system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, learning disability or recent bereavement.

Care planning and involvement in decisions about care and treatment

Patients confirmed that they felt involved in decisions about their care and treatment. They told us diagnosis and treatment options were clearly explained. They told us they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do and returning. They also told us they felt listened to and supported by staff and had sufficient time during consultations.

Patients confirmed they were able to contact the practice and speak with staff in a timely and accessible manner. One patient told us they found they always received quick responses when concerns related to their child. The surgery operated a Nurse Practitioner (NP) led telephone consultation system (triage) for urgent or same day appointment requests, for either the GPs or the NP. Patients spoke positively of the system. They expressed confidence in the fact they were listened to and referred appropriately.

Care plans were in place for vulnerable patients. The practice manager informed us that the care plans were not currently held on their computer systems due to an IT problem which was being worked on.

Patient/carer support to cope emotionally with care and treatment

Multi-disciplinary palliative care meetings were held on a monthly basis to discuss the needs of those approaching the end of their life. Systems were in place to appropriately prioritise support required. Patient preferences such as advanced directives were shared only with appropriate healthcare partners to ensure they were met, for example, out of hour's services.

One patient told us the care and treatment they family member had received had been exceptional, another described the support and information they received from all staff at the practice as excellent in all areas. Others described the confidence and trust they had in the surgery and that they had been treated with sensitivity and staff were empathetic. Carers meeting venues were also noted on the practice waiting room notice board.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice conducted its own patient survey with results in September 2013. All patients that attended during a 10 day working period in September 2013 were asked to complete a satisfaction questionnaire. In total 100 questionnaires were given to patients to complete during the study period following their consultation at the surgery. All were completed and returned, a 100% response rate. Overall the results indicated that patients felt the practice offered a very good service.

One of the patients who had chosen to write further detail on a letter attached to the completed CQC comment card informed us of two occasions when staff supported them and their family to get an urgent appointment late in the day. They described their access and treatment by all the staff involved as outstanding. Patients felt that the service was exceptionally good and that their views were listened to and valued by the staff.

All the patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need. Some patients were frustrated at the length of time they had to wait to see their preferred GP. One patient expressed that it would be helpful if the practice was to open on a Thursday afternoon and a Saturday morning. Another patient said that communication in all surgeries, when awaiting results from tests would be improved by being informed of the result, rather than be informed if you hear nothing it's okay, as some patients become anxious.

We saw that interpreter services could be arranged for appointments, staff spoken with were aware of the service but it had yet to be required.

There was literature available signposting patients to healthy activity programmes, therapeutic groups, carers meetings, age concern, information and guidance for men on prostate specific antigen (PSA) testing.

The surgery also assisted patients to gain quick access to urine testing when they were symptomatic such as having blood in their urine. They collected an appropriately person specific labelled sample bottle, completed in full a specific health questionnaire and could leave a urine sample for testing at the surgery. The nursing staff at the surgery would then test and where appropriate forward the sample on to the laboratory in a timely manner. Patients were contacted to either arrange an appointment or receive treatment when appropriate.

The practice had an active patient participation group (PPG) who met every four months and minutes were taken of these meetings. We spoke to a member of the PPG who raised no concerns. The practice struggled to recruit to the PPG young people with families or ethnic minorities, the PPG were aware and endeavoured to encourage participation where possible.

Tackling inequity and promoting equality

Staff had awareness of equality and diversity. The new patient list was open and staff were able to offer appointments to patients, for example patients with no fixed abode. Clinical staff had awareness of the NHS Lancashire North Clinical Commissioning Groups' Equality and Inclusion Strategy 2013-2016. This was designed to tackle current health inequalities, promote equality and fairness and establish a culture of inclusiveness.

Public Health England's data found that the surgeries average male life expectancy was 79.8 and female life expectancy 82.5, compared to England's national average is 78.9 for males and 82.9 for females. Nurses held a number of regular clinics at the surgery to review for example chronic disease management, immunisation and vaccination smoking cessation and diabetes to provide health promotion information and advice.

Access to the service

The practice was purpose built and was visibly clean and well maintained. There was a car park with dedicated disabled bays closest to the door. There was ground level entry to the building. All consultation and treatment rooms were on the ground floor. A disabled toilet and baby change facility was available. Corridors and doorways were wide enough to accommodate wheelchair access. The reception areas were spacious and well furnished with ample seating.

The practice was open between 8am and 6pm with the exception of Thursdays when they closed at 1pm. We discussed with the practice how they met the needs of the working age population as the largest percentage of the surgery population, 58.6%, were of working status either paid work or in full-time education. We were informed that this was something the partners at the surgery regularly

Good

Are services responsive to people's needs?

(for example, to feedback?)

reviewed to ensure they could meet the needs of their registered patients. None of the patients spoken with or the 43 CQC comment cards received suggested that obtaining urgent appointments had been problematic. Obtaining urgent appointments with their preferred GP was not always possible.

Home visits and urgent same day appointments were available every day. All practice opening times were detailed in the surgery leaflet which was available in the waiting room for patients and website.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the surgery. The manager showed us the complaints summary from November 2013 to August 2014 of which there were seven recorded, both clinical and non-clinical. All were resolved and we saw that each complaint was fully investigated and actioned where appropriate to do so.

We saw that information was available to help patients understand the complaints system and information on how to make a complaint was within the surgery information leaflet, There was also a separate complaints policy in place for the pharmacy dispensary with patient information leaflets available for patients to read.

Patients we spoke with said should they wish to make a complaint they would read the information leaflet or approach the reception staff for advice and further information. None of the patients spoken with had needed to make a complaint about the surgery.

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

Staff told us about the various meetings they attended to help keep them up to date with any new developments, professional updates and of any medical devices alerts or concerns. Staff knew what their responsibilities were and told us they wanted to continue to provide a good service for patients and were enthusiastic about their contribution.

We saw evidence that showed the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people where appropriate to do so.

GPs attended various meetings, medicines management, safeguarding meetings and shared information amongst others and appropriately shared information with their staff team. Staff were aware and engaged with multi-disciplinary team working and had awareness of the CCG's 'Better Care Together' engagement programme. There was a very clear strategic vision in respect of staff roles, responsibilities, staff succession planning, career progression, education and training.

Governance Arrangements

GPs had lead roles and took responsibility for a number of clinical areas. GPs were involved in training and supporting trainee GPs. The GP partners were responsible for decisions in relation to the provision, safety and quality of care and worked with the practice manager and deputy manager to ensure identified risks were acted upon.

Individual aspects of governance such as complaints, risk management and audits within the surgery were allocated to appropriate staff. The practice submitted governance and performance data to the CCG.

The GPs had completed a number of clinical audits, acted on findings and implemented changes where indicated.

Leadership, openness and transparency

The practice had systems to identify, assess and manage risks related to the service. We saw there was clear guidance available for staff in a number of the policies we reviewed. There was evidence of staff involvement in the various minutes of the meetings staff attended and that relevant information was cascaded to all staff groups. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They were aware of the whistleblowing policy and told us they knew who they could go to for support.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example; disciplinary procedures, induction policy and, safeguarding policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed with staff and if necessary changes were made to procedures and staff training put in place.

We saw that audits and checks took place to monitor the quality of services provided and that the findings were acted upon.

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

We saw from minutes of meetings that staff members attended role appropriate meetings and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered.

The 43 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained.

The patient participation group gathered information in response to patient's comments to enable the surgery to listen, act and respond appropriately to local concerns.

Management lead through learning & improvement

There was a clear focus on clinical excellence and a desire to achieve the best possible outcomes for patients. The practice operated an 'open culture' and actively sought feedback and engagement from staff, patients and the CCG all aimed at maintaining and improving the service.

The practice had completed reviews of significant events and other incidents and shared these with staff via

Are services well-led?

Good

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

meetings to ensure the practice improved outcomes for patients. Staff told us about how they learned from "significant events" and the improvements and reviews following any change implementation that took place.

The GPs and managers were very supportive of staff's personal development and provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the service provided to their patients.