Rainbow Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rainbow Medical Centre, St Helen's on 10 March 2015. Overall the practice is rated as good.

Rainbow Medical Centre provided effective, responsive care that was well led and addressed the needs of the population it served. The service was safe, caring and compassionate. It was also good for providing services for all of the population groups.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt were disseminated to staff. Infection risks and medicines were managed safely.
- Patients' needs were assessed and care was planned and delivered in line with current legislation and guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Patients experienced outcomes that were in line with or above the national average. For example, care plans were in place for vulnerable and older patients to reduce unplanned admissions to hospital and annual reviews for people with long term conditions were carried out.
- Patients spoke highly of the practice. They said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice provided good care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice monitored, evaluated and improved services. Staff enjoyed working for the practice and felt

Summary of findings

well supported and valued. There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Ensure a suitable system is in place for identifying and managing local risks associated with the building in which the practice was based. For example general, environmental and health and safety risk assessments, including the risks presented by legionella. (A bacterium found in the environment which can contaminate water systems in buildings).

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to staff to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding lead members of staff. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe and staff were recruited safely.

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, including the Quality and Outcomes Framework (QOF). The practice had achieved higher than national average scores for QOF last year (97.7%). Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older, vulnerable patients and those with long term and mental health conditions. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and there was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were very complimentary and positive about the service and the care and treatment they received. Data showed that patients rated the practice higher than others for several aspects of care. They said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. They

Summary of findings

engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were satisfied with the appointment system and described their experience of making an appointment as good. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded appropriately to issues raised with learning and improvements implemented as a result.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular clinical and staff meetings. The practice proactively sought feedback from staff and patients, which it acted on. They had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and learning and development events.

Improvements were needed to ensure a suitable system was in place for identifying, monitoring and managing general health and safety and environmental risks.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average at 78%. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits to housebound patients, rapid access and extended appointment times for those with enhanced needs.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had around the national average number of patients with long standing health conditions (56% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and conditions. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected and above the national average. For example, patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations.

GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments (for example 30 minute appointments

Summary of findings

for diabetes, asthma and chronic obstructive pulmonary disease (COPD) reviews) and home visits were available when needed. All these patients had a named clinician responsible for their care and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the clinicians worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, the practice maintained a register of vulnerable children and these were highlighted on clinical records. Clinical staff led in child health including safeguarding. Child immunisation clinics were held led by nursing staff and routine six week baby checks were carried out at the practice by the GPs. Immunisation rates were above average for all standard childhood immunisations. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them. Appointments were available outside of school hours and the premises were suitable for children and babies. Children under the age of five would be seen the same day. Older children were also considered and discussed with the GP if they presented with an acute problem. We saw good examples of joint working with midwives, health visitors and school nurses. For example there were weekly community midwife clinics held at the practice.

Facilities at the practice included a parent and child room to support breast feeding mothers and those with young children.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group such as smoking cessation. The practice offered extended opening hours for patients who worked with a range of early morning and evening appointments, telephone consultations and telephone advice.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments (30 minutes) for people with a learning disability. The practice had a well-developed care plan programme for the most vulnerable 2% of patients and these had a named doctor. Clinical staff were trained to care for vulnerable patients such as those with substance misuse problems and those terminally ill.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their safeguarding responsibilities.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). There was a high prevalence of mental illness in the St Helen's area and the practice worked well with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Ninety six percent of people experiencing poor mental health had an agreed documented care plan and 89% of those diagnosed with dementia had received a review of their care in the preceding 12 months. The practice carried out advance care planning discussions for patients with dementia.

The practice had accurate registers to inform the service and to deliver full assessments of patients' needs. The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND and Live Life Well (a local based online service set up by mental health services in St Helen's). Patients with a mental health crisis were accommodated, where possible, with same day appointments with a preferred clinician, outside of normal working hours if necessary. Reception staff were trained and were sensitive to the needs of these patients.

Summary of findings

What people who use the service say

We spoke with 11 patients on the day of our inspection (including seven members of the Patient Participation Group). We received 21 completed CQC comment cards. We spoke with people from a range of age and population groups. They included older people, those with long term and mental health conditions and those with children.

All patients were positive about the practice, the staff and the service they received. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in July 2014 demonstrated they performed well with 94% of respondents saying they had confidence and trust in the last GP they saw or spoke with and 100% had confidence and trust in the last nurse they saw or spoke with. Eighty three percent said the last GP they saw or spoke to was good at treating them with care and concern, 90% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety percent said they last GP they spoke to or saw was good at listening to them, whilst 85% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing above average for the majority of questions asked.

We received no concerns regarding the appointment system on the day of inspection from patients we spoke with and the comments cards reviewed. Patients told us they were able to get an appointment or speak to a GP on the same day in the case of urgent need. Sixty four percent of patients responding to the National GP Patient Survey said it was easy to get through to the surgery by phone (this was below the national average). However 73% of respondents described their experience of making an appointment as good, with 90% saying the last appointment they got was convenient. Only 54 % of respondents with a preferred GP got to see or speak to that GP. patients

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure a suitable system is in place for identifying and managing local risks associated with the building in which the practice was based. For example general, environmental and health and safety risk assessments, including the risks presented by legionella. (A bacterium found in the environment which can contaminate water systems in buildings).

Rainbow Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP, a specialist advisor who was a Practice Manager and a second CQC inspector.

Background to Rainbow Medical Centre

Rainbow Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 14000 patients living in the St Helen's area of Merseyside. The practice has nine GPs (four male and five female), a business manager, practice nurses, administration and reception staff, data, IT and support staff. The practice is also a GP training practice, offering support and experience to trainee doctors. Rainbow Medical Centre holds a General Medical Services (GMS) contract with NHS England.

The practice is situated over two sites, one at Robins Lane and a branch surgery at Elephant Lane, St Helen's. The patients can attend either site and staff work across both sites. We visited Robins lane practice on our inspection.

The practice is open across both sites Monday - Friday 8.30am to 6pm. There are extended opening hours on Monday and Thursday evenings. They are closed one half day per month for staff training and development. Patients can book appointments in person, online or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of St Helen's Clinical Commissioning Group (CCG). Fifty six percent of the patient population has a long standing health condition, whilst 65% have health related problems in daily life. There is a much higher than national average number of patients claiming disability allowance.

The practice opts in to provide out of hours services via a consortium arrangement known locally as St Helen's Rota. They provide a service locally in Prescot.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band 6 representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

Detailed findings

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

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 our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice at Robins Lane including the administrative areas. We reviewed premises management of Elephant Lane practice also. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection. These patients attended both practices.

We spoke with the practice manager, registered manager, GP partners, a GP registrar, practice nurses, administrative staff and reception staff on duty who worked across both practices. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety. We looked at some recent significant events from 2014 and 2015 which had been analysed, reported and discussed with relevant staff.

Evidence showed the practice had managed incidents and events consistently over time and so could show evidence of a safe track record over the long term. The practice manager, GPs and any other relevant or involved staff investigated and reported the significant events. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. The minutes of practice meetings showed that complaints, incidents and significant events, were discussed. They were a standing item on the practice meeting agenda and we were told that an annual review took place to identify trends and themes and to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided.

We looked at the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs, practice nurses and practice manager. Learning was disseminated to the whole practice team where relevant. GPs told us significant events were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and is currently causing an epidemic in West Africa). They also told us relevant alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had up to date safeguarding child and adults procedures in place. They also had links to the local safeguarding authority's policies and procedures on the practice computer system. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw that this information was displayed in all clinical and administrative areas.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff had a higher level of training than other staff. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and

how they were cared for. Staff were made aware through an alert system on the computer and electronic records of vulnerable people and their immediate families. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had dedicated GP and practice nurse as leads in safeguarding. They were supported in their roles by administrative staff. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead completed all requested reports for child protection and serious case review meetings. All staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern. 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; for example children subject to child protection plans. The clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings and with multi-disciplinary teams.

The practice had a current chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told that only staff who had been trained and had the relevant Disclosure and Barring Service (DBS) checks acted as a chaperone; this included some receptionists and administrative staff. We saw, in each clinical room, a list of staff who could act as a chaperone for clinical staff to refer to. A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedure in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. There was also a temperature monitoring probe inside the fridge which enabled checking of temperatures over time periods to ensure medicines were stored at a constantly maintained safe temperature. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Processes were in place to check medicines were within their expiry date and suitable for use. Stock rotation and control was evident to ensure medicines and equipment were used according to date. All the medicines we checked were within their expiry dates. Medicines for use in medical emergencies were kept securely in the treatment rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked for function regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis. There was a system in place for monitoring and checking of medicines carried in GP bags.

The practice staff and GPs were supported by the medicines management team from the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team visited the practice and regular meetings were held with them.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing

staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place however the practice did not maintain records of the monitoring of these schedules. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were processes in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities, couches were washable and clean and curtains were washed and changed six monthly or more frequently if needed. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves were available in the treatment/consulting rooms.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and clinical waste products were evident in order to protect the staff and patients from harm.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Infection control training was undertaken by all staff and they and received annual updates. An appropriate level of training and updates were evident for different roles (clinical and non-clinical). Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling specimens/ samples safely.

An infection control audit was undertaken by the community infection control team annually. We saw the outcome report with actions implemented. The practice re audited every three months to ensure actions had been implemented and improvements seen. Improvements had been made to the environment as a result. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw evidence of this displayed in all clinical and treatment rooms.

The practice did not undertake regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). A risk assessment determining the risks presented had not been undertaken however the practice regularly ran the water taps in the premises as this had been suggested to lower the risk.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for annual checks of fire extinguishers and portable appliance testing (PAT). All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers and blood pressure measuring devices.

Emergency equipment and medicines were stored together on an emergency trolley. There was one located on both floors of the practice. There was an oxygen cylinder, nebulisers and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). A range of medicines that may be useful in an emergency were stored safely and were well organised and accessible. The equipment and medicines were maintained and checked regularly.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements 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 were arrangements in place to ensure suitable cover and staffing levels were maintained during periods of absence such as sickness or 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. They had recently undertaken a staffing and skill mix review which confirmed staffing levels were suitable to meet patients' needs.

We saw evidence of clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) and there was a system in place to ensure these were monitored and checked regularly.

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 weekly, monthly and annual 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 for the practice. This was the practice business manager. We did not see evidence of risk assessments in place for the general environment, health and safety and Control of Substances Hazardous to Health (COSHH) For example detailing how to manage the risks from certain chemicals, environmental or equipment risks.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

Staff identified and responded well to patient's needs. They were trained and experienced and could identify when a patient was in need of urgent attention. Systems were in place to identify vulnerable patients so that staff could care for them in a specific manner to minimise risks to their health. For example young children or patients on an 'at risk' register were highlighted so that reception staff could identify them so that appropriate appointments were given such as on the day urgent appointments.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. 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 a heating company to contact if the heating system failed. Staff we spoke with were aware of the business continuity plan and could describe what to do in the event of a disaster or serious event occurring for example in the event of an IT failure.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Records showed that all staff had received training in basic life support and this was updated regularly according to professional guidelines. There were suitable emergency equipment and medicines available including access to oxygen and an automated external defibrillator. Appropriate emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff knew the location of the equipment. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this event.

We saw the practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that fire fighting equipment and fire safety equipment (such as fire alarm) were routinely checked and maintained under contract. Records showed that staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately. NICE guidance was stored on the shared drive in the computer system so that staff had easy access to them. We saw minutes of practice meetings where new guidelines were disseminated. 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. The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, children subject to a child protection plan, patients with long term conditions and those on the palliative care register.

GPs and practice nurses led on and managed specialist clinical areas such as safeguarding, and various chronic diseases such as diabetes, heart disease, asthma, mental health and dementia. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions and those on the palliative care register.

Older patients and those with long term conditions and mental health needs including dementia were well cared for by the practice. All vulnerable older patients and patients at risk of unplanned admission to hospital had care plans in place which were routinely reviewed with the extended multi-disciplinary team. Patients were given extended 30 minute appointments for their review and there was a recall system in place to chase up those not attending. All patients who had had a non-elective admission to hospital were reviewed within 72 hours of discharge. Care plans were implemented for patients with dementia and they received an annual review. Data showed the practice was above the target for carrying out annual reviews for patients with long term and mental health conditions such as dementia, chronic obstructive pulmonary disease (COPD), asthma and diabetes.

National data showed that the practice referral rates to secondary and other community care services for all conditions were average. All GPs we spoke with used national standards for the referral of patients with suspected cancers, referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were carried out. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were scanned onto the system daily and distributed to the relevant GP. In the absence of the named GP for the patient the duty doctor would assess and action this information.

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

We saw data of the practice's performance for antibiotic prescribing, which was comparable to similar practices nationally. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved consistently good scores for QOF over the last few years which demonstrated they provided good effective care to patients (last year they obtained a QOF score of 97.7% which was above the national average). QOF information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. QOF information also indicated that patients with long term health conditions received

Good

Are services effective?

(for example, treatment is effective)

care and treatment as expected and above the national average. For example patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Child immunisations rates were above the national average.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Clinical staff were supported in lead roles by administrative staff. The practice kept up to date disease registers for patients who were vulnerable and for those with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).These registers were used to identify and monitor patients' health needs and to arrange annual health reviews.

The practice had a system in place for completing clinical audit cycles. Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision, locality performance indicators and QOF. Examples of clinical audits included atrial fibrillation and stroke risk stratification, (2012 re-audit 2015), recording of cancer treatments and metastases (2014 and re-audit 2015) and Rheumatoid arthritis and osteoporosis risk. We looked at some of these audits that the practice had undertaken. Some of these were fully completed audits where the practice was able to demonstrate the changes made since the initial audit. Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they received feedback through training days and at meetings.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice implemented the Gold Standards Framework for end of life care. One of the GPs took the lead for this group of patients supported by the practice nurse and administration staff. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings. The patient's care plan and any other relevant information were shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction check list in place which identified the essential knowledge and skills needed for new employees. We spoke to a new member of staff who confirmed that they had received an induction however; we did not see any documentation. All staff received an employee handbook which was kept up to date and reviewed. This handbook contained all relevant policies and procedures.

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training such as basic life support, infection control, fire safety and safeguarding. We noted a good skill mix among the doctors and nurses with them having undertaken additional training courses in specific disease management of clinical fields. The practice manager kept a record of training carried out by all staff. We noted that the system was not easy to follow and did not enable training needs to be identified easily to ensure good monitoring and management of training and development. The practice manager told us that they would develop a system to enable them to maintain more detailed information about all training undertaken that would also help them to plan for future training needs

Annual appraisals that identified learning needs from which action plans were documented were carried out for all staff. We spoke to staff who told us the practice was supportive of their learning and development needs. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We spoke with trainee GPs who felt supported by the practice in their learning and development. All GPs were up to date with their continuing professional development requirements and they had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller

Good

Are services effective?

(for example, treatment is effective)

assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The GPs took the lead in clinical areas such as long term conditions, mental health illness and the elderly. The GPs were supported by the practice nurses in these roles such as leads for diabetes and heart disease. The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in these roles.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles (for example treating patients with long-term conditions such as asthma, COPD, diabetes and family planning) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers and health visitors to support patients and promote their welfare. The practice held multidisciplinary team meetings (monthly) to discuss the needs of complex patients, for example those with end of life care needs, vulnerable adults or children on the at risk register where concerns about their welfare had been identified. Gold Standards Framework meetings were held and liaison occurred with district and palliative care nurses to review the needs of patients and their families on the palliative care register.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately. However, there was no formal mechanism in place for monitoring patient information was acted on in a timely manner.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital within 72 hours. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the practice and these staff which confirmed good working relationships between them and good review and joint decision making in patient care.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004. They provided us with examples which demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all procedures such as contraceptive coil implants and joint injections a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with documentation of explanation and consent obtained in the records.

Health promotion and prevention

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

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, obesity management and travel advice.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible. However new patients were still able to register even if they did not undertake a new patient health check. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic advice on lifestyle.

The practice also offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was above both the national and CCG average. Seasonal flu immunisation rates for the over 65 group were also above the CCG average. There was a clear policy for following up non-attenders by the named practice nurse.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks. Practice records showed 88% of patients on the dementia register had received a review in the last 12 months.

The practice's performance for cervical smear uptake was 82%, which was better than others nationally. There was a named nurse responsible for following up patients who did not attend screening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area to avoid being overheard. Staff told us about how they would treat patients whose circumstances may make them vulnerable and ensured they were able to access care without prejudice.

Consultations took place in purposely designed rooms with screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We looked at 21 CQC comment cards that patients had completed prior to the inspection and spoke with 11 patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey 2014 found that 83% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. Ninety percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Eighty five percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good.

The practice offered patients a chaperone service prior to any examination or procedure. Information about the chaperone service was seen displayed in the reception area and all treatment and consultation rooms.

Care planning and involvement in decisions about care and treatment

Patients whom we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, in the National GP Patient Survey 2014, 86% of patients said the GPs were good at involving them in decisions about their care and 89% felt the nurses were good or very good at involving them in decisions about their care. These results were average when compared nationally.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to, supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice and rated it well in this area. Members of Patient Participant Group said they had received help to access support services to help them manage their conditions and in times when emotional and psychological support was needed.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians were empathetic and compassionate. Results from the National GP Patient Survey told us that 90% of patients said the last GP they saw or spoke to was good at giving them enough time, 90% said the GP was good at listening to them and 85% said they were good at explaining tests and treatment.

Good

Are services caring?

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice staff were able to refer patients on to counselling services. The practice signposted carers to support led by community services.

Information was on display in the waiting area about the support available to patients to help them to cope emotionally with care and treatment. Information available included information about the Citizen's Advice Bureau, mental health services, domestic violence and community support groups for people who were isolated or carers. The Citizen's Advice Bureau held a drop in service at the practice weekly to support patients.

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 patients' needs and had systems in place to improve and maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered home visits and extended appointments for those with enhanced needs. This was to ensure patients had appointments to meet their needs for care and health reviews. Housebound patients were visited on an annual basis to review their needs and conditions. Patients received their relevant annual health checks and had care plans in place that were reviewed regularly.

The practice cared for a small number of elderly adult patients who lived in local care or nursing homes. Clinical staff undertook visits to review care plans, new patients and medications. Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. Clinical staff took the lead for chronic diseases and conditions. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had an active Patient Participation Group (PPG). We spoke with seven members of the group and looked at their agendas and meeting minutes. Practice staff attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon. The PPG contributed to the practice patient survey, reviewed the results and worked with the practice to improve services.

Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There were suitable waiting areas for patients attending an appointment and car parking was available including disabled parking spaces. There were disabled toilet facilities and an induction hearing loop. There was a dedicated mother and baby room which provided facilities for breast feeding and nappy changing.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. They had tailored services and support around the populations needs and provided a good service to all patient population groups.

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

The practice had recognised the needs of different groups in the planning of its services. For example, they supported and provided care to patients in receipt of support from a local homeless charity. The local area had a high number of substance misuse patients and three of the GPs were trained in the management of drug misuse.

Access to the service

The Practice hours operated across both sites from 8.30hrs to 18.00hrs on week days with one half day closure per week at each site. They hold twice weekly late night surgeries until 20.00hrs. Early morning and late evening appointments were available.

Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of

Good

Are services responsive to people's needs?

(for example, to feedback?)

hours medical provider. The practice offered pre bookable and urgent (on the day) appointments and home visits. Appointments could be made in person, by phone or online. Text messaging was used to remind patients of appointments and to inform of certain test results. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition and these patients were always offered a same day or urgent appointment.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and toe vulnerable housebound patients.

Patients we spoke with, comment cards and patient survey results told us patients were satisfied with the appointment system. They told us there was usually no difficulty getting through to the practice on the telephone or getting an appointment. The practice performed well in patient surveys for access to the appointments system with 81% satisfied with the practice's opening hours. However only 64% said they found it easy to through to the practice by phone. The practice had identified this as an issue with the telephone system and was implementing new systems to address the issue. Seventy three percent described their experience of making an appointment as good.

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. The practice business manager managed the complaints and liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. We saw the summary log of complaints and these included verbal comments and those complaints that had been resolved immediately or within 24 hours. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

We saw that information was available to help patients understand the complaints system (such as a summary leaflet and information on the website); however there was no information displayed in the reception/waiting areas for patients to see. Patients we spoke with were aware of the complaints procedure. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. We noted this did not detail information regarding other contacts to which a patient could raise concerns such as the local NHS England team and the Care Quality Commission. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and ethos to support patients from birth to the end of their lives and to treat them with humanity and compassion. We did not find that the vision or a mission statement was displayed for staff and patients to see. However the practice had a statement of purpose that included the aims and objectives of the service and was available if requested. Staff we spoke with were able to articulate the vision and values of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice computer system. Policies and procedures were dated and reviewed appropriately. Staff confirmed they were aware of how to access them however there was no system in place to demonstrate that all staff had read and understood them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and certain long term conditions; GP leads for safeguarding, palliative care, learning disability and mental health. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above the national average. For 2013/14 the practice obtained 97.7%. We saw that QOF data was regularly monitored and discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Clinical audits were undertaken regularly by nursing and medical staff. We looked at a selection of these. Generally they were completed well; with review of actions and improvements evident.

The practice had arrangements in place for identifying and managing risks such as fire, however there was no general health and safety or environmental risk assessments for the practice sites. There was a nominated health and safety representative, this was the business manager who told us they would action this and implement a risk assessment.

The practice held regular practice and clinical meetings that were documented. We looked at sample minutes from these and found that performance, quality and significant events and complaints had been discussed. The practice had identified that there was a communication gap in that practice meetings did not involve all the staff at the same meetings. They told us consideration had been given to this and they were going to implement regular practice meetings that involved the whole staff team

Leadership, openness and transparency

We saw from minutes that staff meetings were held regularly, at least monthly. 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. We also noted that learning and development days were held every month.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example being open, bullying and harassment, recruitment and selection policies which were in place to support staff.

Staff felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued, their views about how to develop the service were listened to and acted upon and suggestions for improvements considered and acted upon. The leadership of the practice was caring, enthusiastic and motivated about the service they provided and about caring for their staff.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received, Friends and Family test and the PPG. We looked at the results of the annual patient survey that was reviewed and

Are services well-led?

Good

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

actions were contributed to by the PPG. We found that improvements had been made following results of one survey. For example further training had been given to reception staff in communication skills.

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate. Information was promoted in reception to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. There were links to the Friends and Family test survey on the website. We saw that the last results demonstrated 94% of patients surveyed would recommend the practice to friends and family.

We saw that in February 2015 the practice had undertaken a patient participation enhanced service evaluation. This looked at the function of the PPG and included actions to improve PPG and the practice working together. There was evidence of actions taken in response to PPG information and suggestions.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events.

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

Management lead through learning and improvement

We saw that all staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and a good two way process. The practice had an induction programme however this was not fully documented. Staff undertook training relevant to their role.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice had training and development half days each month at which staff would undertake training or learning though electronic means and attended CCG wide development session.

The practice was a GP training practice and we found that trainee doctors were well supported by the GPs and other staff.

The practice had completed reviews of significant events, complaints and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients.