Manchester Road Medical Centre

Quality Report

27-31 Manchester Road
Knutsford
Cheshire
WA16 0LY
Tel: Tel: 01565 633101
Website: www.mrmc.practiceuk.org.uk

Date of inspection visit: 10 December 2014
Date of publication: 05/03/2015

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

This is the report of findings from our inspection of Manchester Road Medical Centre. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 10 December 2014 at the practice location in Knutsford. We spoke with patients, relatives, staff and the practice management team.

The practice was rated overall as Good. There were some elements of the practice that were outstanding. They provided effective, responsive care that was very well led and addressed the needs of the population it served. The service was safe, caring and compassionate.

Our key findings were as follows:

- The practice had a good track record for maintaining patient safety. Effective systems were in place to ensure patients were safe from risks and harm. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Staff were safely recruited. Infection risks and medicines were managed safely.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Patients experienced outcomes that were above the national average.
- Patients spoke highly of the practice. They were very pleased with the individualised care given by all staff. They told us staff were kind, caring and compassionate and treated them with dignity and respect.
- The practice provided good care to its population that was responsive to their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- The practice monitored, evaluated and improved services. They worked in collaboration with the CCG and NHS England. Staff enjoyed working for the practice and felt well supported and valued. The practice was well led by partner GPs and management that articulated visions for the future.

Summary of findings

:

We saw some areas of outstanding practice including:

- The practice worked creatively with commissioners, neighbourhood practices and community organisations and implemented initiatives which improved patient care. These included Caring Together (a system of joined up health and social care locally for the well-being of elderly, frail patients), Neighbourhood team meetings, and the implementation of a health and well-being co-ordinator.
- The leadership team articulated its vision and values to staff, patients and the public. They valued and invested in their staff and motivated them to provide an excellent service to their patients.

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

Information and data from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable and proactive safeguarding lead members of staff. The practice was proactive in identifying, supporting and sharing information in order to safeguard patients and when appropriate, made safeguarding referrals.

Are services effective?

Good

Outcomes for patients were routinely better than average and expected; because there was on-going monitoring and continuous improvements for patients were made as a result. National and local data showed that some patients' outcomes were above average for the locality, including the Quality and Outcomes Framework (QOF). This practice had achieved high scores for QOF over the last few years (last year they obtained 98.5%). The National Institute for Health and Care Excellence (NICE) guidance was accessible, discussed, referenced and used routinely. The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older patients and those with long term and mental health needs. Clinical staff took the lead for various conditions and services supported by other staff. They had undertaken further training in relation to these roles. Patients were fully involved in development of their care and treatment plans. Patients' needs were delivered in line with current legislation and guidance. This included assessment of capacity and health promotion.

Staff who delivered care and treatment had a role in monitoring and assessing quality, clinical audit and the development and review of policies, procedures and practices. They were well trained appropriate to their roles and any further training needs had been identified. The practice was proactive in ensuring staff had the right skills and experience to provide care and treatment. They carried out annual appraisals and personal development plans were in place for all staff. Good multidisciplinary team working was evident.

Summary of findings

Are services caring?

Good

Results from the national GP patient survey, patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality

Are services responsive to people's needs?

Good

The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. The practice worked creatively with commissioners, neighbourhood practices and community organisations and implemented initiatives which improved patient care. They worked with the other three practices in Knutsford to provide health services through a health and well-being co-ordinator (contracted from Age UK) to older patients. The practice also supported and utilised the 'Good Neighbours' scheme which was a befriending and support service operated in conjunction with a local charity organisation.

The practice had implemented an innovative, effective telephone and appointments triage system to ensure patients were able to access care and services quickly and easily in response to needs. Access to appointments was good with the practice performing well in patient surveys in respect of access to the practice and appointments. They responded well to the specific needs of patients by offering length of appointment times that were suitable to their needs. The practice worked innovatively with other health and social care providers to comprehensively assess the needs of the practice population and take action to meet these needs. There was evidence of proactive outreach programmes and service adaptations aimed at meeting the needs of their patients.

Complaints were responded to appropriately and there was an accessible complaints policy and procedure.

Are services well-led?

Good

Staff were clear about and able to articulate the practice values and vision and their responsibilities in relation to these. They were proud of the practice, its culture and the service it provided for its patients. There was a clear leadership structure with staff taking responsibility for lead roles in the practice. Staff were well supported by a passionate, innovative leadership team that motivated staff to deliver high quality care and services. The practice had policies and procedures in place to govern activity. Strong governance

Summary of findings

arrangements across the practice were proactively reviewed and adapted to ensure best practice was implemented and maintained. A variety of regular clinical and business meetings and multi-disciplinary meetings took place and were documented. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and acted upon this.

The leadership team articulated a vision to provide extended health and social care services in conjunction with other providers in an environment suitable for developing future needs.

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 had a higher than average population of elderly patients. The practice supported these patients very well. Care and treatment was delivered in line with current published guidelines and good practice and the practice performed well against key indicators for this patient group. 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. It offered a range of enhanced services, for example, avoiding unplanned admissions, shingles catch up for the elderly and seasonal flu vaccinations. It was responsive to the needs of older patients, and offered home visits and extended appointments for those with enhanced needs. The GPs supported older patients living in care and nursing homes locally. They visited each week to review patients' needs, care plans and medicines.

The practice had implemented initiatives to care effectively for elderly patients such as Caring Together (a system of joined up health and social care locally for the well-being of elderly, frail patients). Neighbourhood team meetings were piloted at the practice and had been extended across the Clinical Commissioning Group. These are multi-disciplinary meetings to share information and plan care and treatment for their elderly patients. The practice provided double time appointments for elderly patients with complex needs such as limited mobility to ensure they received a full appointment slot and review of their needs. All older patients had care plans in place which were routinely reviewed with the extended multi-disciplinary team.

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 had a higher than average number of patients with long standing health conditions (62% 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 condition. 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 patient 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.

Clinical staff had lead roles for the majority of long term conditions. We saw that GPs and nurses were appropriately trained in the area they led and in most cases the lead would be supported by another clinician, for example a GP led on cardio vascular disease supported by the nurse who had undergone specific training for the role. Patients with long term conditions were routinely given extended appointments to ensure thorough reviews and medication checks were carried out. For example patients with diabetes were given half hour appointments for their reviews.

We spoke to patients with long term conditions at the inspection, they all said they received very good care and treatment; staff treated them with care, compassion and respect. The practice was accessible to disabled patients with allowances made for those patients who could not use the stairs to reach the first floor consultation rooms

Families, children and young people

Good

The practice served a lower than average younger population. 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.

Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. They had undertaken a review of children at risk and liaised effectively with other agencies and health and social care professionals in minimising risk for those children.

We found that there was a higher than average uptake of children receiving their childhood immunisations. The practice ran weekly baby clinics with the practice nurse leading on this. They offered a full range of childhood vaccinations and liaised closely with the health visitors and school nurses in caring for babies and younger

Summary of findings

patients. The practice had a dedicated breast feeding room for mothers. The practice responded well to children who were unwell. The GP First appointment system allowed for, and the practice ensured, that children and babies who were unwell were rung back by the GP within a short period of time (usually half an hour). This meant those younger patients who were more vulnerable were appropriately triaged.

Working age people (including those recently retired and students)

Good

The practice had a slightly lower than average working age population. The practice cared for this population group well with care and with compassion. The practice offered extended opening hours once per week for patients who worked. They held flu vaccination clinics on a Saturday to help uptake for working patients with clinical conditions putting them at risk. Telephone consultations were available and appreciated by working patients. The practice offered online services including booking of appointments, ordering of repeat prescriptions and telephone consultations that supported working patients. They provided a full range of health promotion and screening that reflected the needs for this age group.

The GP First telephone triage system for appointments supported access for patients of working age. They were able to have a telephone consultation with a GP at a convenient time of the day.

People whose circumstances may make them vulnerable

Good

The practice was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team and with the extended multi-disciplinary teams, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead was a GP who had received appropriate training.

The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. They carried out annual health checks for people with a learning disability and cared for a group of patients with learning disabilities living in local supported care settings. They offered longer appointments for people with a learning disability when needed. The practice supported patients living in a traveller's community. They ensured care, treatment, information and advice was tailored to meet their needs.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice provided GP services to patients who were resident in a local mental health unit. One of the GPs took the lead for mental health and had additional training relevant to this.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection (including two members of the Patient Participation Group) and we received 30 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions and those with babies and children.

All patients were extremely positive about the practice, the staff and the service they received.

They told us staff were helpful, caring, confidential and compassionate and that nothing was too much trouble for any of the staff. Patients told us staff gave them time, listened to them and they were treated as individuals Doctors were very professional and caring. Patients told us the environment was clean and hygienic.

All comments received from speaking to patients, comment cards received on the day and from the patient survey were extremely positive. Patients felt this was the best practice around. Two patients commented that sometimes they had to wait to get an appointment with their preferred GP; however they acknowledged this was their choice. All patients told us they were seen very promptly in case of need on the same day.

We received no concerns regarding the appointment system. Eighty one percent of patients responding to the NHS GP patient survey said it was easy to get through to the surgery by phone. Eighty one percent described their experience of making an appointment as good.

Patients were very pleased with the care and treatment received from the practice. They told us they were treated with dignity and respect and 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 told us that 92% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 84% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 87% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety six percent said they last GP they spoke to or saw was good at listening to them, whilst 90% said the GP was good at explaining treatment and tests and 95% had confidence and trust in the GP. The data demonstrated the practice was performing average and above for the majority of questions asked.

Outstanding practice

- The practice worked creatively with commissioners, neighbourhood practices and community organisations and implemented initiatives which improved patient care. These included Caring Together (a system of joined up health and social care locally for the well-being of elderly, frail patients), Neighbourhood team meetings, and the implementation of a health and well-being co-ordinator.
- The leadership team articulated its vision and values to staff, patients and the public. They valued and invested in their staff and motivated them to provide an excellent service to their patients.

Manchester Road 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 an expert by experience.

Background to Manchester Road Medical Centre

Manchester Road Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 7100 patients living in and around Knutsford. The practice has three GP partners, two salaried GPs, a practice manager, practice nurses, healthcare assistants and administration and reception staff. The practice is also a GP training practice, offering support and experience to trainee doctors.

The practice is open Monday to Friday from 8.30am to 6.30pm with an extended surgery on Thursday until 8.15pm. They are closed one half day per month for 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 Eastern Cheshire Clinical Commissioning Group (CCG). The practice is situated in an affluent area with low deprivation. The practice population is made up of a higher than national average older population and a lower than national average of patients aged under 40 years. Sixty two percent of the patient population has a long standing health condition and there is a lower than national average number of unemployed.

The practice does not deliver out-of-hours services. These are delivered by East Cheshire NHS Trust who provides a service locally in Macclesfield.

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.

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?

Detailed findings

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 including the administrative areas. 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.

We spoke with the practice manager, registered manager, GP partners, a GP registrar, practice nurse, administrative staff and reception staff on duty. 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. We also talked with family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe track record

Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development. Significant event reporting had taken place for over fourteen years at the practice, well before the legislative need to do so. Significant events were submitted to the CCG via an electronic reporting system. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff. We noted there had been few complaints received by the practice and none of these had been serious complaints regarding clinical care.

The practice had systems in place to monitor patient safety. The practice manager, GPs and any other relevant or involved staff investigated and reported the significant events. Documented evidence confirmed that incidents were appropriately reported. 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. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

The minutes of practice meetings we reviewed showed that complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A standardised template was used for the reporting of all incidents. This included category of description of events, what went well, what could have been done better, what action has been agreed and what learning ensued. Each incident was rated as to the level of risk incurred. A summary log was also held of all events that occurred over the year.

We looked at the records of eight significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place where necessary and that findings were disseminated to relevant staff at meetings and training and development days. For example we reviewed and discussed two incidents regarding the medicines fridge. This demonstrated lessons had been learnt and action taken (the purchase of an additional fridge) to prevent recurrence. There was evidence of review of significant events to analyse themes and trends in order to improve learning and practice. We saw that action plans for the significant events were revisited to ensure all actions were completed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so.

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 and practice manager and learning disseminated to the whole team when 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. The team recognised the benefits of identifying any patient safety incidents and near misses.

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 up to date safeguarding child and at risk adults, policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were easily available to staff on their computers

and in hard copy. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical, reception and administrative areas.

All staff had received training on safeguarding children and adults. 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.

One of the GPs took the lead for safeguarding children and another GP led for at risk adults. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead attended local case conferences when able due to time constraints and had completed 100% of requested reports. All staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings

The practice had a current chaperone policy. Only clinical staff acted as a chaperone. 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 procedures 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. All medicines that we checked were found to be in date.

Medicines for use in medical emergencies were kept securely in a cupboard in one of 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 meningitis and anaphylaxis.

The practice had a medicines lead administrative role supported by the GP lead for medicines management. Their role was to ensure patient safety in prescribing, including repeat prescribing. They were also supported by the medicines management team of 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.

Spare prescription pads were stored securely. Repeat prescriptions were held securely in the administration office. We saw these were not pre signed. Prescriptions waiting for collection were monitored to ensure they had all been collected and patients were not missing their medication.

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.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had undertaken an infection control audit in November 2014. We saw the outcome report with actions implemented. Improvements had been made to the environment as a result, for example hand cleanser dispensers were available in all clinical areas. Cleaning was carried out under contract and the cleaning standards and schedule was monitored. The practice nurse was lead for infection control. They had received training in infection control and this was updated annually.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact

in the event of accidental injury. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

Infection control training was undertaken by all staff. Appropriate level of training and updates was 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 submitted specimens.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable. Privacy curtains in the treatment rooms were dated to identify when they were last replaced.

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.

Regular testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings) had not taken place. However we were told that plans were in place to have this done in the near future.

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). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and an automated external defibrillator. These were maintained and checked regularly.

Staffing and recruitment

An up to date recruitment policy was in place. This was in line with current guidance and regulations. We looked at a sample of seven recruitment files for doctors, reception, administrative staff and practice nurses. The practice employed locum GPs. We saw evidence they had independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists.

We found that all the required information relating to workers was available in the staff files that we looked at. There were appropriate Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks for the clinical staff (including practice nurses and GPs). CRB and DBS checks for non-clinical staff had not been carried out; however these staff did not undertake chaperoning duties. Other required information seen included two references obtained prior to employment, evidence of relevant qualifications and training, contracts, photographic identification and job descriptions.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning. This was well managed. We noted that the practice had ensured that enough staff were rostered to be available to manage the busy Christmas period..

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The

Good

Are services safe?

diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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 regular required checks of the building, the environment, medicines, staffing and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see. An up to date risk assessment log was seen. Each risk was assessed, rated and control measures recorded to reduce and manage the risk.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Paper records were stored in a basement in suitable cabinets; however the door to the basement was not locked. The practice told us they would rectify this immediately.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. This comprehensive plan detailed risk identification and risk assessments for the business. It covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Staff we spoke with were knowledgeable about the business continuity plans 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.

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment and medicines available that were checked and maintained.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and using current best practice guidance. 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. One of the GPs was lead at the practice for NICE guidelines. We found that NICE and other guidance was disseminated and discussed with all concerned and at regular clinical meetings. 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, patients on the 'at risk' register and palliative care register.

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 high scores for QOF over the last couple of years (last year they obtained 98.5%) which demonstrated they provided good effective care to patients. 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 care and treatment as expected and above the national average including 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 practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding, minor surgical procedures and various chronic diseases. 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 with poor mental health with external health and social care workers.

The practice provided services for people in the local community including an older than average population with a lower than average number of unemployed, patients living in more affluent areas and those experiencing long term health conditions with a higher than average life expectancy . We found GPs and other staff were familiar with the needs of each patient and the impact of the socio-economic environment.

The GPs took the lead in clinical areas such as patients with long term conditions 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. Older patients were well cared for by the practice. Initiatives such as Caring Together and Neighbourhood teams had been rolled out across the CCG following implementation at the practice. Caring Together is a system of joined up health and social care locally for the well-being of elderly, frail patients. Neighbourhood team meetings were multi-disciplinary meetings held to share information and plan care and treatment for their elderly patients. All older patients had care plans in place which were routinely reviewed with the extended multi-disciplinary team. Care plans were developed in conjunction with the patient; they were given a copy of the care plan and were encouraged to contribute details and information to it.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions reflected the national standards for referral rates. All GPs we spoke with used national standards for referral, for example in suspected cancers. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP. In the absence of the named

Good

Are services effective?

(for example, treatment is effective)

GP for the patient the duty doctor would assess and action any such information. Patients who had been discharged from hospital received a review by the GP within 72 hours (as per national guidelines).

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 that the GPs and clinicians ensured consent was obtained and recorded for all treatment including written consent for minor surgical procedures. One of the GPs undertook joint injections and minor surgical procedures. They did this in line with their registration and NICE guidance. The GP was appropriately trained to carry out this procedure and they ensured their skill and knowledge was kept up to date.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice performed well and above national average. The practice regularly monitored its performance against QOF standards at clinical and team meetings. We discussed with the GPs and they showed us data from the local CCG of the practice's performance against enhanced services. This was detailed and monitored performance indicators for primary care. They regularly benchmarked their performance to other locality practices.

We looked at some audits that the practice had undertaken. Examples of clinical audits included; joint injections audit, care of coeliac patients, minor operations and anticoagulation in Atrial Fibrillation. We looked at and discussed some of the clinical audits that had been undertaken in the last 12 months. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We were given examples of where audits had improved patient outcomes and ensured the practice worked within NICE guidelines, for example in the use of anticoagulants in atrial fibrillation.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision and locality performance indicators. As an example, we saw an audit of treatment of coeliac disease. An outcome from this audit included increased awareness in clinical staff of regular and annual blood tests for patients. 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.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and reporting, clinical audit and reviews, managing child and adult safeguarding and medicines management.

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

The staff induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and role specific induction. We saw examples in some of the more recent employee's induction (including GPs and administrative staff). The checklists were complete and had been signed by the manager and staff member.

We saw a training matrix which identified subjects and the dates completed. The training matrix demonstrated that staff were mostly up to date with mandatory training such as health and safety, information governance and safeguarding of vulnerable adults and children. The practice manager showed us evidence to demonstrate some training topics that needed refreshing were planned and booked in for January. Staff also had access to additional training related to their role. For example reception staff had received training in customer care and dealing with difficult patients. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development personal to their role.

Good

Are services effective?

(for example, treatment is effective)

We found that all staff had received an annual appraisal. Staff had supervision on an informal and formal basis including one to one and group sessions. A GP registrar told us they had received a good induction and was well supported and supervised at the practice. The administrative staff also told us they were well-supported by their line manager and the rest of the practice team.

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. There was a rota for their supervision and their clinical practice was reviewed regularly.

All GPs were up to date with their yearly 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 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 practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, administration of vaccines and cervical cytology.

The practice ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

The practice worked well with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the out of hours service with information, to support, for example, end of life care. Information received from other agencies, for example the accident and emergency department or hospital outpatient departments were 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. The GPs and the practice manager attended various meetings for management and clinical staff involving practices across Eastern Cheshire CCG and in particular the three practices in Knutsford.

These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and practices were benchmarked.

The practice attended various multidisciplinary team meetings at regular intervals such as to discuss the needs of complex patients, for example those with end of life care needs, children at risk, older frail patients and those with mental health and learning disabilities. These meetings were attended by community staff such as district nurses, health visitors, social workers and palliative care nurses. Decisions about care planning were documented.

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 to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment). The consent policy and procedures included Gillick competency and how to assess this and had links to further national and professional body guidance. One of the GPs was lead for the nursing home patients they looked after and demonstrated knowledge and understanding of Deprivation of Liberty safeguards and their application relevant to patients living in care settings.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and joint injections a patient's written consent was obtained and documented in the patient notes.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available.

Within the practise there were stands and notices advising and signposting to support services. For example there was information about carer's support, Health watch and childhood health promotion. The practice had recently held an open day at which health promotion featured. Staff we spoke with were knowledgeable about advisory and support services and how to access them.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered reviews with the nurse.

The practice offered a health check to all new patients registering with the practice and 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 average for the CCG. Seasonal flu immunisation rates for the over 65 group were also above average for the CCG.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual health check. There were local health and support groups that they accessed and referred patients who were elderly, had poor mental health or learning disabilities needs.

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. They had all received training in equality and diversity, confidentiality and dignity and respect; this was updated on a regular basis. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area so as to avoid being overheard.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and 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.

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

Care planning and involvement in decisions about care and treatment

Patients 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.

We saw that healthcare professionals were knowledgeable about and adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardians. One of the GPs was the lead for the registered patients living in the practice allocated nursing homes. Within this role they were involved in advance care planning, Do Not Attempt Resuscitation (DNAR) decision making and capacity assessments. The GP had received training for this.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic and compassionate. Results from the national GP patient survey told us that 95% of patients said the last GP they saw or spoke to was good at giving them enough time, 96% said the GP was good at listening to them and 90% said they were good at explaining tests and treatment. Ninety two percent of responses said the last GP they saw or spoke to was good at treating them with care and concern.

The practice had a GP lead for patients coming towards the end of their lives and terminally ill and were supported by the practice nurse and administratively. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings minutes. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

GPs and clinical staff had a method of identifying and supporting bereaved patients through the flag system on the medical records. They followed up bereaved families / carers with a phone call. They provided support and signposted patients to bereavement support. The practice informed the wider multi-disciplinary team of any deaths and this was highlighted to staff so that they could offer support if a family member was on the phone or present in the practice.

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, and offered home visits and extended appointments for those with enhanced needs. They provided double time appointments for older patients with complex needs such as limited mobility. This was to ensure patients had a full appointment in which to receive good care and health reviews. Patients with poor mental health received annual health checks and had care plans in place that were reviewed regularly.

The practice cared for a number of elderly adult patients who lived in a local care home. One of the GPs was lead for these patients and undertook a visit each week to review care plans, any 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. 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 worked closely with other health and social services in provision of additional GP services to a number of care providers for elderly and mentally unwell patients. The practice supported patients in a local care home. The practice housed the Royal Voluntary Service (RVS) and supported them to provide services in the practice to older patients with dementia. The practice worked with the other three practices in Knutsford to provide health services through a health and well-being co-ordinator (contracted from Age UK) to provide services to older patients. The practice also supported and utilised the 'Good Neighbours' scheme which was a befriending and support service operated in conjunction with a local charity organisation. The scheme helped elderly patients and people with mobility issues get to doctors' appointments and hospital visits and provided support and friendship.

The practice provided services to a group of patients with learning disabilities living in local supported care. These patients had annual health checks, care plans that were reviewed with the multi-disciplinary team and given longer appointments to support good care and treatment.

The practice had an active Patient Participation Group (PPG). We spoke with a member of the group and looked at their annual report and meeting minutes. The practice manager and a GP 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 had its own box for comments in reception that it monitored.

Tackling inequity and promoting equality

The practice was aware of the challenges they faced with their population. They are situated in an affluent area of Cheshire with a higher than average elderly population. This presents its own health challenges with a higher than average number of patients with long term conditions and co-morbidity.

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. The practice provided equality and diversity training for all staff. Records we saw demonstrated that all staff had completed the required training and were up to date. They had tailored services and support around the populations needs and provided an excellent service to older patients and those with long term conditions.

The premises and services met the needs of people with disabilities. The medical centre was located in an adapted house. There were disabled toilet facilities and an audio loop system in place in reception. Patients with limited mobility were catered for. Consultations and treatments

Good

Are services responsive to people's needs?

(for example, to feedback?)

were offered in ground floor rooms, patients who had difficulties with mobility or learning disabilities were given extended appointments to ensure they were properly assessed and treated.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This was the practice manager who 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. Complaints were investigated thoroughly. A summary and overview log was recorded which broke down the complaints into subjects and themes. Complaints were reviewed regularly at meetings to analyse themes and trends in order to improve learning and practice.

Patients we spoke with were all 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. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone.

Access to the service

The practice was open Monday to Friday 8.30am until 6.30pm with extended opening hours once a week until 8.15pm. They were closed one day per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advise and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments, telephone consultations and home visits. Appointments could be made in person, by phone or online. The practice had implemented an effective GP telephone triage system for consultations and appointments, the 'GP First' system. Patients who rang the practice were informed a GP would ring them back within a time slot. This was also a time that was convenient to the patient. Priority was given to children, babies and vulnerable or patients identified as at risk due to their condition and these patients would be contacted first within the hour to triage their health needs.

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 those vulnerable housebound patients. The practice had identified it had a larger than average number of housebound patients that they supported with the GP telephone triage system.

Patients whom 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 and they all said the GP First system worked well. The practice performed well in patient surveys for access to the appointments system with 81% saying they found it easy to through to the practice by phone and 81% described their experience of making an appointment as good. Overall satisfaction with the practice (at the last patient survey) was good; 88% of patients described their overall experience of the practice as good, which was higher than the national average.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to support patients and to provide a high quality service delivered in a friendly and caring manner. Staff were able to articulate the vision and values of the practice. The GP partners worked together to develop a strategy. There was good evidence of collaborative working in that the three practices in Knutsford were planning to build a new health centre to house all three practices and to provide other supportive services with the aim to improve access to intermediate care and reduce hospital admissions. The practice had identified the limitations to the current building and had vision for future developments for improved patient care and outcomes.

The practice strategy was reviewed regularly, every six months by the partners. One of the partners had undertaken a clinical leadership course to support their role in business planning. They used some time in the training and development days to plan for the future with staff.

Practice leaders articulated and promoted values with staff. An emphasis was placed on customer care. Staff could tell us about the values promoted to them from interview, induction, training and continuous articulation of - 'smiling over the phone', 'never leave patients waiting', and 'the customer comes first'.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the offices. Policies and procedures were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

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; GP leads for safeguarding, nursing home patients, learning disability and mental health. GPs took the lead for various conditions and non-clinical practice business such as finance and IT. We spoke with staff of varying roles 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 98.5%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

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. Risk assessments and risk management was in place.

Leadership, openness and transparency

There was a well-established clearly identified leadership structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership which articulated vision and motivated staff to provide a good service. The leadership of the practice was passionate, caring, enthusiastic and motivated about the service they provided and about caring for their 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 practice leaders articulated a philosophy of caring for their staff as well as patients. They treated staff as equals and rewarded them for their support and service. They took time to know their staff, their backgrounds and lives and were able to

Are services well-led?

Good

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

support them in any difficulties they had by having an understanding. They held team building away days such as an annual rounder's competition, go karting and other social events.

The practice held a variety of meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events. All staff were involved in meetings and were able to contribute to improvements and service delivery initiatives.

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

We looked at complaints and found they were well managed. The practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the event.

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. A suggestion box was situated in the reception area to encourage patient feedback. 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. Information regarding Healthwatch was also promoted in reception.

There was a whistleblowing policy in place. 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. Regular monthly meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had. Staff were able to detail examples of where their suggestions had been acted on by the practice leadership team, for example in respect of the administration and reception areas that staff felt were overcrowded, disorganised and did not promote safe working practices. Staff were encouraged to be involved and planned a revamp of these areas themselves. They now work in an environment that they planned as suitable and conducive to good working practice. Staff were proud of their achievements and the improvements they had made.

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 and a training and development policy and procedures to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff undertook a wide range of relevant training.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. Staff potential was recognised and used when planning for future developments. For example the practice had recently implemented a new role of Healthcare Assistant (HCA). They had identified a member of staff keen to undertake the role and had invested in training and development for this person.