

Rainhill Village Surgery

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?	Requires improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rainhill Village Surgery on 27 September 2016. Overall the practice is rated as good. The practice is rated as requiring improvement for providing safe services and good for providing effective, caring, responsive and well led services.

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

- The practice had been established for many years and is a traditional family practice situated in a converted Victorian house. The practice had a ramp for disabled access but no doorbell or intercom to gain access through the surgery door. There were translation and signers for the deaf services, but no hearing loop. The practice has a set of steep steps to access the second floor treatment room, which would be difficult for some patients to use and the emergency services to utilise if needed.
- Information reviewed from the GP national patient survey and patient comment cards indicated patients were happy with the service provided and that they could easily get an appointment.
- The practice was in the process of a changeover of practice manager and senior partner and had recently installed a new computer system.
- There were systems in place to mitigate safety risks. However, there were gaps in some safety processes. For example, there was out of date medical equipment and printer blank prescription forms were insecurely stored.
- Information about services and how to complain was available. However, this information needed updating and more work could be done in terms of analysing complaints.
- The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Summary of findings

- Patients' needs were assessed and care was planned and delivered in line with current legislation.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice sought patient views about improvements that could be made to the service; including having a patient participation group (PPG) and acted, where possible, on feedback.
- There was an open and transparent culture and staff worked well together as a team. Staff received training and appraisals to support them carry out their roles.

There was an element of outstanding practice:

- The practice took part in a trial to reduce antibiotic prescribing for respiratory illness whereby patients were encouraged to have alternative remedies where possible. Results showed a 10% decrease in antibiotic prescribing over a year.

The areas where the provider must make improvements are:

- Have a system in place to monitor the medical equipment used to ensure that it is in date and dispose of any that has expired.

The areas where the provider should make improvements are:

- Revisit chaperone training for both GPs and staff to ensure all involved are following the correct procedures.
- Review processes in place to make sure complying with all current Health and Safety regulation. For example, check all blank prescriptions are securely stored and that all materials are clearly labelled and have appropriate safety data information available or displayed.
- Update their complaints information both in the practice leaflet and on the website to reflect patients can complain to either NHS England or the practice.
- Implement a system to review trends in incidents and complaints and review any complaint to see if it should be escalated to a significant event.
- Have a doorbell or intercom system so that those patients who have difficulty opening the inner door to the practice can be assisted.
- Retain documented recruitment information, such as references, for all staff.
- Correspond with any referring GP when patients are treated from other practices to outline the treatment received and any outcome or follow up care required.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. This was because, we found the following on inspection:-

- Out of date medical equipment and no system to monitor expiry dates.
- Issues with regards to some procedures in place. For example, storage of blank prescription pads and having correct safety data available or displayed for some materials in use.

The practice did however learn from internal incidents and safety alerts, to support improvement and these were discussed at staff meetings. Staff understood their safeguarding responsibilities. There were appropriate recruitment checks in place. Staff had access to emergency medication and equipment.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. Some clinical audits demonstrated quality improvement. Staff worked with other health care teams. Staff received training suitable for their role.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients' views gathered at inspection demonstrated they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patient access was important to the practice and 92% of respondents to the GP national patient survey (July 2016) described their experience of making an appointment as good (CCG average 70%, national average 73%).

Information was available about how to make a complaint. However, this needed to be updated to reflect patients could either make a complaint to the practice or NHS England. Complaints were appropriately investigated and discussed at staff meetings but more work could be done in terms of analysing complaints.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. The practice proactively sought feedback from staff and patients and had an active PPG. Staff had received inductions and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for providing services for older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and offered home visits and care home visits. The practice participated in meetings with other healthcare professionals to discuss any concerns. There was a named GP for the over 75s.

Good



People with long term conditions

The practice is rated as good for providing services for people with long term conditions. The practice had registers in place for several long term conditions including diabetes and asthma. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. One of the GPs had a special interest in diabetes and held a diabetic clinic for those patients with more complex needs.

Good



Families, children and young people

The practice is rated as good for providing services for families, children and young people. The practice regularly liaised with health visitors to review vulnerable children and new mothers. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Good



Working age people (including those recently retired and students)

The practice is as rated good for providing services for working age people. The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible. There were online systems available to allow patients to make appointments.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for providing services for people whose circumstances make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and

Good



Summary of findings

longer appointments were available for people with a learning disability. Foodbank vouchers were available. The practice had a carer's champion who acted as a first point of contact for patients and liaised with the local carer's centre.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for providing services for people experiencing poor mental health. Patients experiencing poor mental health received an annual physical health check. All practice staff had received dementia awareness training and were dementia friends.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 (from 110 responses which is approximately equivalent to 1.6% of the patient list) showed the practice was performing in line with or higher than local and national averages in certain aspects of service delivery. For example,

- 92% of respondents described their experience of making an appointment as good (CCG average 70%, national average 73%).
- 95% patients said they could get through easily to the surgery by phone (CCG average 66%, national average 73%).
- 80% said they usually waited 15 minutes or less after their appointment time to be seen (CCG average 64%, national average 65%).
- 88% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).

In terms of overall experience, results were higher compared with local and national averages. For example,

- 91% described the overall experience of their GP surgery as good (CCG average 84%, national average 85%).

- 92% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 77%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards, of which 21 were very complimentary about the service provided. Patients said they received an excellent, caring service and patients who more vulnerable were supported in their treatment. Eight comments also highlighted how easy it was to get an appointment. Only one negative comment was about the telephone system which the practice was in the process of addressing.

We reviewed information from the NHS Friends and Family Test which is a survey that asks patients how likely they are to recommend the practice. Results for June to August 2016 from eight responses showed that, five patients were either extremely likely or likely to recommend the practice and three responses said unlikely.

Rainhill Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP and practice manager specialist advisor.

Background to Rainhill Village Surgery

There were 6797 patients on the practice register at the time of our inspection and 26% of the practice population were over 65 years of age (compared to a national average of 17%).

The practice is a training practice managed by three male GP partners and three salaried GPs (one male, two female). There is a nurse clinician and two practice nurses and one healthcare assistant. Members of clinical staff are supported by a practice manager, reception and administration staff.

The practice is open 8am to 6.30pm every weekday with the exception of Thursdays when the practice closes at midday. Appointment times are Monday to Friday 9am to 11am and 3.45pm to 5.35pm. Thursday 9am to 11am. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hours services, St. Helens Rota.

The practice has a Personal Medical Services (PMS) contract and has enhanced services contracts which include childhood vaccinations.

Why we carried out this inspection

We inspected this service as part of our 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. The 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?

We also looked at how well services were provided for specific groups of people and what good care looked 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)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

The inspector :-

- Reviewed information available to us from other organisations e.g. the local clinical commissioning group (CCG).
- Reviewed information from CQC intelligent monitoring systems.

- Carried out an announced inspection visit on 27 September 2016.
- Spoke to staff and representatives of the patient participation group.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

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.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events and incidents. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The practice carried out a thorough analysis of the significant events. We reviewed an example of an event and could see the practice had updated its emergency telephone call handling protocol as a result. Significant events were discussed at staff meetings, but further improvement could be made by identifying any trends to prevent reoccurrence. In addition, information from complaints could be proactively reviewed to see if they need to be escalated to a significant event.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.

Staff were aware of recent safety alerts and these were discussed at staff meetings. The practice acted on any medication safety alerts.

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected local requirements. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding vulnerable adults and children. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. For example, GPs had received level three child safeguarding training. Health visitors attended quarterly clinical meetings to discuss any concerns.
- There was no notice in the waiting room to advise patients that chaperones were available if required but they were available in consultation and treatment rooms. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, in conversation with two members of staff, it was not clear if GPs and staff were always following correct chaperoning procedures.
- The practice was clean but cluttered in places with many notices on the walls. Monitoring systems and cleaning schedules were in place. Cleaning equipment was not colour coded according to national guidelines, but was labelled as to what cleaned where. Cleaning equipment used to clean the waiting room area was also used to clean areas in treatment/minor surgery rooms. Cleaning materials with safety data sheets were available, but one bottle was unlabelled and it was unclear what was in the bottle. Similarly safety information for a hazardous material in one of the nurses' rooms could not be read due to a label over it.
- The nurse clinician was the infection control clinical lead. There was an infection control protocol and staff had received up to date training. Infection control audits were undertaken by the local infection control team and action plans were in place to address any shortfalls. There were spillage kits and appropriate clinical waste disposal arrangements in place. Consulting rooms were carpeted; but some procedures were being carried out in one of the consulting rooms, which would require a treatment area with higher standards of cleanliness.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Emergency medication was checked for expiry dates. Blank prescription pads for home visits were securely stored but printable prescriptions were not secure. There were systems in place to monitor their use.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However,

Are services safe?

references for a recently employed GP were not available on file, but we were told the recruiting GP had seen references. The applicant's health was asked about at interview but there was no record kept.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. However, this information is for staff and it was displayed in the patient waiting area rather than in a staff area. The practice had up to date fire risk assessments. The risk assessment had failed to note that oxygen was on the premises and there were no safety signs warning where oxygen was stored. The practice had carried out regular fire safety equipment tests and fire drills. Staff were aware of what to do in the event of fire and had received fire safety training as part of their induction.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. However, we found a variety of out of date equipment. We were concerned some of the equipment especially in the second floor nurses room would be used in error that day, so we asked the deputy manager to remove the out

of date equipment immediately, which they did. We were told one of the practice nurses took responsibility for monitoring equipment but was on long term sick leave.

- The practice had a variety of other risk assessments in place to monitor safety of the premises such as Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator and oxygen. We were shown the equipment was regularly checked. There were first aid kits and an accident book available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients and held regular meetings to discuss performance. (QOF is a system intended to improve the quality of general practice and reward good practice). Results from 2014-2015 were 98% of the total number of points available with lower than local and national exception reporting. The practice had recently had a new computer system installed and it was unclear at inspection how patients were recalled for annual reviews.

Performance for mental health related indicators was comparable or better than local and national averages for example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 95% compared to local average of 92% and national averages of 88%.

One of the GPs had a special interest in diabetes and held a diabetic clinic for those patients with more complex needs. Performance for diabetes related indicators was comparable with local and national averages for example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2014 to 31/03/2015) was 80% compared with a local average of 82% and national average of 78%.

The practice carried out a variety of audits. For example, medication audits, minor surgery audits and clinical audits. However, these could be expanded to improve patient outcomes.

The practice took part in a trial to reduce antibiotic prescribing for respiratory illness whereby patients were encouraged to have alternative remedies when possible. Results showed a 10% decrease in antibiotic prescribing over a year.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as infection prevention and control, fire safety, health and safety and confidentiality. The practice had GP locums and locum induction packs were available.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Training included: safeguarding, fire safety awareness, equality and diversity, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules. Staff told us they were supported in their careers and had opportunities to develop their learning.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. However, the practice had

Are services effective?

(for example, treatment is effective)

recently started a clinic for joint injections for patients from other practices and there were no follow up letters sent to patient's GPs to explain the treatment provided. We discussed this with the GP who agreed to send correspondence. The practice also provided emergency cover for another practice for half a day a week when they were closed and vice versa. The practice did have access to summary care records and was currently working towards a data sharing agreement with having a new computer system installed.

- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of

legislation and guidance, including the Mental Capacity Act 2005. GPs were aware of the relevant guidance when providing care and treatment for children and young people. Consent forms were used for minor surgery.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice. This included patients who required advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice carried out vaccinations and cancer screening and performance rates were comparable with local and/or national averages for example, results from 2014-2015 showed:

- Childhood immunisation rates for the vaccinations given to two year olds and under ranged from 76% to 97% compared with CCG averages of 70% to 97%. Vaccination rates for five year olds ranged from 94% to 98% compared with local CCG averages of 91% to 98%.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 85% compared to a national average of 82%.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Results from the national GP patient survey published in July 2016 (from 110 responses which is approximately equivalent to 1.6% of the patient list) showed patients felt they were treated with compassion, dignity and respect. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 92% said the GP gave them enough time (CCG average 88%, national average 87%).
- 88% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%).
- 94% said they found the receptionists at the practice helpful (CCG average 84%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. Results from the national GP patient survey showed patients responded

positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable or above local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 88% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%)
- 81% said the last GP they saw was good at involving them in decisions about their care (CCG average 83%, national average 82%)

Staff told us that telephone translation services were available. The practice website could be translated into other languages. All practice staff had received dementia awareness training and were dementia friends.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had a register of 179 carers on its list. Information was available to direct carers to the various avenues of support available to them on the practice website and on a designated noticeboard in the waiting room. The practice had a carer's champion who was the first point of contact for patients and liaised with the local carers' centre.

Staff told us that if families had suffered bereavement, their usual GP visited them or offered a longer appointment to meet the family's needs or signposted those to local counselling services available. Information was also available on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups. For example;

- There were longer appointments available for people with a learning disability or when interpreters were required.
- Home visits were available for elderly patients.
- Urgent access appointments were available for children and those with serious medical conditions.

There were a range of services available including:-

- minor surgery and joint injections
- INR clinic (for patients on anticoagulant medication)
- ECG, phlebotomy if required, 24 hour blood pressure monitoring and spirometry.
- Visiting midwife
- Baby clinics
- Vaccinations and immunisations
- NHS Health checks
- Chronic disease clinics for example, diabetes management.
- Foodbank vouchers

Access to the service

The practice is open 8am to 6.30pm every weekday with the exception of Thursdays when the practice closes at midday. Appointment times are Monday to Friday 9am – 11am and 3.45pm to 5.35pm. Thursday 9am – 11am. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hours service St Helens Rota.

Results from the national GP patient survey published in July 2016 (from 110 responses which is approximately equivalent to 1.6% of the patient list) showed that patient's satisfaction with how they could access care and treatment were higher compared with local and national averages. For example:

- 83% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.

- 92% of respondents were able to get an appointment to see or speak to someone last time they tried (CCG average 84%, national average 85%).
- 95% patients said they could get through easily to the surgery by phone (CCG average 66%, national average 73%).
- 80% said they usually waited 15 minutes or less after their appointment time to be seen (CCG average 64%, national average 65%).
- 92% of respondents described their experience of making an appointment as good (CCG average 70%, national average 73%)

The practice had a text appointment reminder service.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Information about how to make a complaint was available in a practice information leaflet at the reception desk and on the practice website. The complaints policy clearly outlined a time frame for when the complaint would be acknowledged and responded to and made it clear who the patient should contact if they were unhappy with the outcome of their complaint. However, the information did not make it clear patients could either complain to NHS England or the practice.

The practice discussed all complaints at staff meetings. We reviewed a log of previous complaints and found both written and verbal complaints were recorded and written responses included apologies to the patient and an explanation of events. The practice received very few formal complaints. Complaints were categorised annually according to the theme of the complaint. Further improvement could be made by implementing a system to analyse complaints further to see if they should be escalated as a significant event and to identify any trends.

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 described their purpose as to provide their patients with the highest quality NHS general medical services available under the NHS. The partners met regularly but there was no formalised business plan available to us. The practice was undergoing a change of leadership and succession planning was underway at the time of our inspection.

Governance arrangements

Evidence reviewed demonstrated that the practice had:-

- A clear organisational structure and a staff awareness of their own and other's roles and responsibilities.
- Practice specific policies that all staff could access on the computer system.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information. Meetings were planned and regularly held including: Clinical meetings every week, reception staff meeting every three months. Other meetings included: palliative care meetings with other healthcare professionals and safeguarding meetings with the health visitor.
- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place.
- The practice did use audits but this could be expanded.
- Proactively gained patients' feedback and engaged patients in the delivery of the service and responded to any concerns raised by both patients and staff.

Leadership, openness and transparency

Staff felt supported by management. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues with the practice manager or GPs and felt confident in doing so. The practice had a whistleblowing policy and all staff were aware of this.

The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service when possible.

- There was an established PPG and the practice had acted on feedback. For example, the practice had a ramp installed in the car park to help with patient access after the PPG had suggested this.
- The practice used the NHS Friends and Family survey to ascertain how likely patients were to recommend the practice.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practice team took an active role in locality meetings. Clinicians kept up to date by attending various courses and events. The practice was planning to be part of a scheme that proactively referred patients they thought were at risk to the falls prevention team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>There was no system in place to check whether medical equipment on the premises was in date and therefore safe to use. There were several items out of date in cupboards in treatment rooms which were in use.</p> <p>This was in breach of regulation 12 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>