# The MacMillan Surgery

## Quality Report

The St Chads Centre
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Date of inspection visit: 25 February 2015
Date of publication: 26/03/2015

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 from our inspection of The MacMillan Surgery. The MacMillan Surgery is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 25 February 2015 at The MacMillan Surgery. We reviewed information we held about the services and spoke with patients, GPs, and staff.

Overall the practice is rated as good.

Our key findings were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care. The practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The staff worked well together as a team.

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

The provider should:

- Implement a system whereby it is clear what training staff have received and when they are due to receive refresher training.
- Ensure all staff are up to date with infection control training.
- Ensure policies and procedures are practice specific.
- Carry out a risk assessment regarding the availability of oxygen for response to medical emergencies.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their role however some training needed to be updated.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand the local services available. We also saw that staff treated patients with kindness and respect.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients welcomed the open access clinics and had the benefit of the practice being located in a health centre and therefore they could easily access other services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and learning points from complaints were discussed in practice meetings.

**Are services well-led?**

Good

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern activity but these were mainly generic and needed to be made practice specific. There were systems in place to monitor and improve quality and identify risk. The practice had not had a practice manager in place for several months. Although work was being managed by several

# Summary of findings

staff, the lead GP conceded that they were aware that a practice manager would benefit the administration systems within the practice. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients who are 75 and over and care plans were in place for these patients.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. All these patients had as a minimum a structured annual review to check that their health and medication needs were being met. The practice had adopted a holistic approach to patient care rather than making separate appointments for each medical condition. The practice was situated in a medical centre with easy access to other services such as phlebotomy. The practice also signposted patients to lifestyle management services.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. One practice nurse was the safeguarding lead for the practice. There were systems in place to identify and follow up children living in disadvantaged circumstances and also cases of domestic violence. The lead GP met with the health visitor on a weekly basis to discuss any cases.

The practice had open access clinics available every weekday morning and had separate facilities for nursing mothers. The midwife visited the practice once a week and there were immunisation clinics available.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example there were open access clinics available every weekday morning and one late evening surgery. The practice offered online prescription ordering with a 24 hour turn around and online appointment services. Telephone consultations were available instead of patients having to attend the practice.

# Summary of findings

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Annual health checks for people with a learning disability were carried out and health action plans updated. The lead GP was the clinical lead for drug and alcohol misuse for Knowsley and the practice worked closely with staff from the crime reduction initiative who attended the practice every fortnight to ensure patients who were more vulnerable received appropriate care and support.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services. The practice participated in enhanced services for dementia and used screening tools to identify those patients at risk. The practice encouraged its staff and patients to become dementia friends.

# Summary of findings

## What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 35 comment cards and spoke with two members of the Patient Participation Group (PPG). All comments received indicated that patients found the reception staff helpful, caring and polite and some described their care as excellent.

For the surgery, our findings were in line with results received from the National GP Patient Survey. For example, the latest national GP patient survey results showed that in January 2015, 94% of patients described their overall experience of this surgery as good (from 91 responses). Ninety five per cent found the receptionists helpful (which is higher than the national average).

Results from the National GP Patient Survey also showed that 100% of respondents find it easy to get through to this surgery by phone 92% of patients said the last GP they saw or spoke to was good at treating them with care and concern which is higher than the national average.

## Areas for improvement

**Action the service SHOULD take to improve**

- Implement a system whereby it is clear what training staff have received and when they are due to receive refresher training.
- Ensure all staff are up to date with infection control training.
- Ensure policies and procedures are practice specific.
- Carry out a risk assessment regarding the availability of oxygen for response to medical emergencies.

# The MacMillan Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and practice manager specialist advisor.

## Background to The MacMillan Surgery

The MacMillan Surgery is located in Kirkby, Merseyside, which is a deprived area of the country. The practice had recently relocated to the second floor of a purpose built medical centre which houses other clinics and a walk in centre. The practice has a shared waiting room and reception area with another practice. The practice patient list size had been steadily growing over the past year but the practice had, without notice, received a sudden influx of patients from a practice which was in the process of closing down. The practice had received approximately 400 new patient applications in the past six weeks taking the total number of patients on the day of our inspection to 3030.

The practice is led by one GP and there are two salaried and two locum GPs. In addition there are three nurses and a nurse practitioner and locum nurse practitioner, reception and administration staff. The practice is open 8.00am to 6.30pm Monday to Friday. The practice has open access clinics every weekday morning from 9am and also offers late evening appointments one day a week. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider (Urgent Care 24). The practice has a PMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

There was no intelligent band monitoring data for this practice as the service had recently moved location. The CQC intelligent monitoring placed the practice in band six for its previous location. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

## Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services 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:

# Detailed findings

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

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

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

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 25 February 2015.

We spoke with a range of staff including two GPs, two practice nurses, reception staff and administration staff, on the day. We sought views from representatives of the patient participation group and looked at comment cards and reviewed survey information. We also spoke with other healthcare professionals who worked with the practice such as the District Nurse.

Good

# Are services safe?

## Our findings

### Safe track record

There was a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process.

### Learning and improvement from safety incidents

Staff were encouraged to complete significant event reporting forms via the practice's computer system The practice held meetings at which significant events were discussed in order to cascade any learning points. We viewed analysis documentation which included details of the events, details of the investigations, learning outcomes including what went well and what could be improved.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook ongoing audits to ensure best practice.

### Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. There was a lead member of staff for safeguarding.

All staff had received safeguarding children at a level suitable to their role for child safeguarding, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. The lead GP held weekly meetings with health visitors to discuss children who may be at risk.

A chaperone policy was available on the practice's computer system. The practice nurses and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training to carry out this role and all staff had received a disclosure and barring check.

### Medicines management

The practice worked with pharmacy support from the local CCG and held meetings both with the Pharmacist and Pharmacy Technician. Regular medication audits were carried out with the support of the pharmacy team to ensure the practice was prescribing in line with best practice guidelines.

The practice had one fridge for the storage of vaccines. One of the practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the treatment room. One of the practice nurses had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

### Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and spillage kits were available.

One of the practice nurses was the designated clinical lead for infection control. There was an infection control policy in place. However staff had not received up to date training on infection control and there had been no recent audit carried out by the practice. However, as the practice did not own the building, the cleaning of the building was monitored separately by the building managers.

Good

# Are services safe?

**Equipment**

All electrical equipment was checked to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

The practice nurse carried out monthly checks on emergency equipment such as the defibrillator.

**Staffing and recruitment**

Staff told us there were enough staff to meet the needs of patients and they covered each other in the event of unplanned absences. The practice had recently had an influx of new patients registering at the practice and had appointed new clinicians to cope with the demand.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff working at the practice had received a disclosure and barring service check to ensure they were suitable to carry out their role. Many staff had been employed by the practice for many years and we found staff files lacking in some recruitment documentation and training information.

**Monitoring safety and responding to risk**

The practice was situated in a large health centre and there was a building manager responsible for the compliance with fire, Legionella and other health and safety regulations for the premises.

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. There was a health and safety policy available for all staff. The practice had recently carried out a fire drill.

**Arrangements to deal with emergencies and major incidents**

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Clinicians working on their own also had their own personal panic alarms. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises but no oxygen. Oxygen was available on the ground floor in the walk in centre. There was a first aid kit and accident book available. There was no formal medical emergency protocol in place but when we discussed medical emergencies with staff, they were aware of what to do. One significant event that we reviewed was about a medical emergency and this had been dealt with appropriately. The practice had held discussions after the event to see what went well and what if anything they could have improved.

The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do if faced with a major incident.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Once patients were registered with the practice, the practice nurses carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. Patients were booked in for half an hour to discuss their needs and to also be introduced to what services were available in order for patients to make best use of the practice. The practice nurses referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date.

The practice used a system of 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, learning disabilities and palliative care register.

There were a number of effective assessment systems in place. For example, elderly patients who had any fractured bones were screened and assessed for osteoporosis; patients with long term health conditions were screened for depression at their review appointments.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice.

All GPs and nursing staff were involved in clinical audits. Examples of audits included antibiotic and antipsychotics prescribing. Some audits such as domperidone medication had resulted in no further use and the audits had been closed. Other audits affected very small numbers of patients and did not due to patient's individual circumstances demonstrate any change in practice. The practice had monitored the increase in patients and their needs and had adjusted the service provision accordingly.

The practice also met with the local (CCG) to discuss performance. The practice held a Personal Medical Services (PMS plus) contract whereby the practice was awarded for improving outcomes for example increasing the uptake of screening for various cancers and immunisation rates.

**Effective staffing**

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff received training that included: - safeguarding vulnerable children, basic life support and information governance awareness. There was no training schedule in place to demonstrate what training staff had previously received or were due to receive but it was clear some training in particular infection control needed to be updated. The practice was closed for half a day a month to accommodate training that was organised by the local CCG.

The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurses were given protected learning time and supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). There were annual appraisal systems in place for all other members of staff.

**Working with colleagues and other services**

Incoming referral letters requiring action were immediately passed to the nurses prior to scanning the information onto the patient's notes.

Patients were referred to hospital using the 'Patient Choose and Book' system and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral.

Good

# Are services effective?

## (for example, treatment is effective)

The practice liaised with other healthcare professionals such as the Community Diabetic Specialist, the Community Matron and the Community Mental health and wellbeing Nurse.

**Information sharing**

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were analysed at a team meeting as necessary. For example, the practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance over a weekend.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

**Consent to care and treatment**

The practice had a Mental Capacity Act policy in place to help GPs with determining mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines but their understanding was varied.

The lead GP was aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice carried out injections for joint disorders and we found appropriate information and consent forms for patients were in place.

**Health promotion and prevention**

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia. The practice made use of a TV screen to alert patients about health issues and the need for attending regular screening and immunisations.

The practice staff sign posted patients to additional services such as lifestyle management and smoking cessation clinics.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey (from 91 responses) also showed that 92% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 93% said the last GP they saw or spoke to was good at listening to them which is higher than the national averages.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

**Care planning and involvement in decisions about care and treatment**

Results from the national GP patient survey showed that 88% said the last GP they saw or spoke to was good at explaining tests and treatments and 89% said the last GP they saw or spoke to was good at involving them in decisions about their care which was higher than the national average Ninety two percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the local average.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

**Patient/carer support to cope emotionally with care and treatment**

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs.

There was supporting information to help patients who were carers on a designated notice board in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice patient list size had been steadily growing over the past year but the practice had, without notice, received a sudden influx of patients from a practice which was in the process of closing down. The practice had received approximately 400 new patient applications in the past six weeks taking the total number of patients on the day of our inspection to 3030.

The practice had monitored the uptake of patients and responded by employing more staff including a locum nurse practitioner to enable them to carry out new patient assessments. Despite there being such a huge increase in patient numbers, the practice's response and management of the situation had caused no interruption to patient care. This was confirmed by patients, staff and affiliated healthcare professionals we spoke with.

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the practice's website. The PPG met quarterly and patient surveys were sent out annually.

We spoke with two members of the group who told us the practice had been responsive to any of their concerns. For example, the practice in response to patient's comments had kept the open access clinics when the practice had relocated.

**Tackling inequity and promoting equality**

The practice had a small proportion of minority groups for whom English was not their first language but it always recorded patient's language and ethnicity at registration. The surgery had access to translation services. The building had appropriate access for disabled people. The practice took into consideration the needs of nursing mothers and had a separate room available.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

**Access to the service**

The practice was open between 8.00am to 6.30pm Monday to Friday and until 7.30pm on a Tuesday. The practice operated an open access clinic every weekday morning. Members of the PPG told us that the open access system worked well and the practice provided 'seamless care'. They told us many of the patients in the local area had to use public transport if they had to access services elsewhere and to be seen for all their needs at the same place was beneficial to the population.

Results from the GP national Patient survey showed 100% of respondents find it easy to get through to this surgery by phone. Patients and reception staff told us patients were always given a choice of who they wanted to see and when they wanted to attend.

**Listening and learning from concerns and complaints**

The practice has 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.

Information about how to make a complaint was available on the practice's website and on the television screen in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log book and there had been very few formal complaints received over the past 12 months. Learning points from complaints were discussed at staff meetings.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the heart of everything they did. They felt that patients should be involved in all decisions about their care and that patient safety was also paramount. Comments we received were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

**Governance arrangements**

The practice had a clinical governance policy in place. The governance policy covered: patient involvement, clinical audit, staffing, and education and risk assessments.

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. However many of the policies were generic and not specific to the practice. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies appeared to be in date but some like the Infection Control policy needed to be reviewed to ensure aspects of the policy were being fully implemented.

**Leadership, openness and transparency**

Staff had specific roles within the practice for example safeguarding and infection control. There had not been a practice manager in place for the past ten months although staff told us they felt supported in their role and we could find no negative impact on patient care. Work had been shared amongst staff, but staff approached various members of other staff if they needed help and there was no oversight of training needs for staff. The lead GP had recognised the need for someone to oversee administration management.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

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

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with two members of the PPG who told us the PPG felt that the practice was responsive to any issues raised by the group. They told us that the practice was very patient centred and had involved patients so that they could have their say in the relocation of the practice premises.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. We also saw evidence that the practice also listened to staff feedback and acted accordingly.

**Management lead through learning and improvement**

The practice worked well together as a team and held meetings for team learning and to share information. However, there was an ad hoc arrangement to when meetings were held and the practice would benefit from a more structured approach. Because it was such a small practice team there was a reliance on informal meetings. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and areas for improvement.