Madeley Practice

Quality Report

Moss Lane
Madeley
Crewe
Cheshire
CW3 9NQ
Tel: 01782 750274
Website: www.madeleypractice.co.uk

Date of inspection visit: 9 January 2015
Date of publication: 19/03/2015

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 9 January 2015 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be outstanding in the responsive domain and good in the safe, caring, effective and well led domains. We found the practice provided good care to older people, families, children and young people, people with long-term conditions, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks.
- There were systems in place to keep patients safe from the risk and spread of infection. Infection prevention systems were in place to monitor and make required improvements to the practice.
- Patients were very satisfied with how they were treated and this was with compassion, dignity and respect. GPs and nurses were good at listening to patients and gave them enough time.
- Not all patients found it easy to get through on the telephone to book an appointment however, most patients reported they got an appointment when needed.

We saw several areas of outstanding practice including:

- The practice recognised the impact of poverty and social care support on the health and wellbeing of their patients and provided services to support patients socially as well as physically. The practice also employed an elderly care facilitator to assess and help to manage risks to older patients in their own home and to reduce social isolation.
- Although the practice did not provide a routine out of hours service, the GPs provided their contact details to the relatives of patients who were very near the end of their life so they could contact them at any time.

Summary of findings

- The practice recognised the specific needs of their teenage patients and held an annual 'teenage birthday clinic' for children aged 14 to 15. Teenagers were offered individual health reviews which included a health assessment and life style advice such as contraception or weight management advice. The practice nurse had audited the services that the practice provided which demonstrated improved health outcomes for patients in areas such as weight management and sexual health.

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

The provider should:

- Put measures in place to prevent the accidental interruption of the electricity supply to the vaccine fridges.
- Introduce cleaning records to monitor that cleaning has been carried out daily in line with the cleaning schedule. The cleaning schedule should be updated to reflect the actions required to prevent the occurrence of legionella as identified in the practice's risk log. (Legionella is a virus found in the environment which can contaminate water systems in buildings).

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the virtual patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. We saw that the

Summary of findings

practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us they were satisfied with the appointment system and could see a named GP or a GP of choice to provide continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice recognised the impact of poverty and social care support on the health and wellbeing of their patients and provided services to support patients socially as well as physically. Examples of this included the practice facilitating the Citizens Advice Bureau to support patients in need of legal support at the practice. Also, all patients over age 85 plus those patients over age 75 who had been assessed as at risk, were provided with home visits from the elderly care facilitator employed by the practice. The elderly care facilitator aimed to identify and support older patients in areas such as falls prevention, application for attendance claims and to reduce social isolation. An audit had been completed by the practice to determine the level of undiagnosed dementia in their practice population. Data was collected as part of this project which included actions such as offering home visits and increased referrals to the memory clinic for patients with dementia.

Although the practice did not provide a routine out of hours service, the GPs provided their contact details to the relatives of patients very near to the end of their life so they could contact them at any time.

The practice responded to the specific needs of their teenage patients and carried out an annual 'teenage birthday clinic' for children aged 14 to 15 years. Teenagers were offered individual health reviews which included a health assessment and life style advice such as contraception or weight management advice.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. We saw that the staff and the culture within the practice strongly demonstrated the vision and values however staff were not aware of the formal vision statement. Patients were informed of the level of service they had the right to expect via the practice leaflet and these rights were based on the practices' values.

Summary of findings

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on including feedback from their virtual PPG. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients with a learning disability. The practice carried out annual health reviews for people with a learning disability and offered them longer appointments if needed. The practice also provided primary medical services and advocacy support for patients with learning disabilities living in a low risk independent mental health hospital.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It informed vulnerable patients about how to access various support groups and voluntary organisations. If a patient was very near the end of their life the GPs visited them twice daily if necessary and provided their contact details to the relatives of these patients so they could contact them at any time.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours

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, including those with dementia. It carried out advance care planning for patients with dementia and had introduced innovative ways of identifying patients with dementia, such home visits. They had robust systems in place to refer patients with dementia to the memory clinic.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

All of the 18 patients we spoke with on the day of our inspection were very complimentary about the care and treatment they received. We reviewed the 26 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were very positive. Patients told us the staff were always friendly, professional, caring, empathetic and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy.

The results from the National Patient Survey showed that 94% of patients said that their overall experience of the practice was good or very good and that 93% of patients would recommend the practice to someone new to the area. These findings were supported on the day of our inspection by the patients we interviewed or gathered comments from. The majority of the patients interviewed, and patient comments on the comment cards, used words such as 'excellent' and 'fantastic' to describe the overall care they receive.

Areas for improvement

Action the service SHOULD take to improve

Put measures in place to prevent the accidental interruption of the electricity supply to the vaccine fridges.

Introduce cleaning records to monitor that cleaning has been carried out daily in line with the cleaning schedule.

The cleaning schedule should be updated to reflect the actions required to prevent the occurrence of legionella as identified in the practice's risk log. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Outstanding practice

The practice recognised the impact of poverty and social care support on the health and wellbeing of their patients and provided services to support patients socially as well as physically. The practice also employed an elderly care facilitator to assess and help to manage risks to older patients in their own home and to reduce social isolation.

Although the practice did not provide a routine out of hours service, the GPs provided their contact details to the relatives of patients who were very near the end of their life so they could contact them at any time.

The practice recognised the specific needs of their teenage patients and held an annual 'teenage birthday clinic' for children aged 14 to 15. Teenagers were offered individual health reviews which included a health assessment and life style advice such as contraception or weight management advice. The practice nurse had audited the services that the practice provided which demonstrated improved health outcomes for patients in areas such as weight management and sexual health.

Madeley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Madeley Practice

A team of three GP partners, a salaried GP, four nurses and one health care support worker provide care and treatment for approximately 6,800 patients. Madeley practice works from the following two separate sites:

Madeley Surgery was converted from a farm house in the early 1980s. During the last 15 years there have been three major extensions and refurbishments to provide six consulting rooms, two treatment rooms, dispensary and teaching facilities. Extra space has been created to house the district nurses, health visitors, physiotherapists, counsellors and outside clinics based at the practice.

Baldwins Gate is a branch surgery located approximately five miles from Madeley. It is a 1930s semi-detached house in the centre of the village. It is open five mornings per week providing primary medical services, a dispensary and a blood testing service.

The practice is a training practice for GP registrars and medical students to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

Before carrying out our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a Health Visitor who works with the practice and representatives for the two care homes that Madeley Practice provided care and treatment for.

We carried out an announced inspection on 9 January 2015 at the main practice. We did not visit the branch surgery at Baldwins Gate during this inspection. During our inspection we spoke with the three GP partners, a GP registrar, a nurse and a health care support worker, two receptionists, the practice manager and 18 patients. We observed how patients were cared for. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and why it was important that they did. For example, all the staff we spoke with on the day of our inspection told us of a recent error in the dispensing of a medicine to a patient. All the staff we spoke with were aware of the changes made to prevent this happening again. The GP partners demonstrated a sound knowledge of their responsibilities in managing significant events.

We reviewed safety records, incident reports and minutes of meetings which demonstrated that significant events were routinely discussed at clinical and non-clinical meetings with all staff. However, there was no system in place to review significant events overtime to identify reoccurring themes and trends.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. There was evidence that the practice had learnt from these and we saw from practice meeting minutes that the findings were shared with all staff. Staff told us there was a blame free culture within the practice which supported them to actively report significant events.

Staff used incident forms to report significant events to the practice manager. The practice manager showed us the system they used to manage and monitor significant events. We tracked three significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the significant events and staff we spoke with were able to describe the changes to procedures made. For example, following an error in the dispensing of a medicine, changes to the standard operating procedure for the management of controlled drugs had been made. Staff we spoke with were aware of the changes made and were able to accurately describe them to us. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with gave examples of recent alerts such as the Ebola crisis that were relevant to the care they were responsible for. They also told us of alerts they had received from the local Clinical Commissioning Group (CCG) regarding which type of diabetic blood monitoring machine to use. Staff told us, and we saw minutes of meetings that confirmed this, that alerts were discussed within clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received recent training in safeguarding children and vulnerable adults at a level appropriate to their role. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. There were safeguarding policies available for staff to refer to and staff we spoke with were able to demonstrate how they would locate them for support and guidance.

The practice had appointed dedicated GPs for safeguarding patients. There was a safeguarding lead for children and a different lead for safeguarding vulnerable adults. We saw training certificates that demonstrated that the GPs at the practice had received level three training for safeguarding children and had completed appropriate safeguarding training for vulnerable adults. All the staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information that made staff aware of any relevant issues when patients attended appointments, for example children who were subject to a child protection plan or a vulnerable adult.

There was a chaperone policy for staff to refer to for guidance and support. Posters informing patients of their right to have a chaperone present during an intimate examination were clearly displayed in the reception area and in consultation rooms. Patients we spoke with were aware of their right for a chaperone to be present during an intimate examination. The practice had risk assessed which staff were the most appropriate to carry out chaperoning duties. We saw that only qualified nurses and health care support workers who had received appropriate chaperoning training and a safeguarding check were permitted to chaperone. We saw training certificates demonstrating that staff had received appropriate training and that Disclosure and Barring checks (DBS) had been carried out for all staff working at the practice. DBS checks are carried out to 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. Staff who chaperoned understood their responsibilities in safeguarding patients and maintaining patient's dignity during an intimate examination.

There was a system in place to support staff in the identification of children and young people who had a high number of A&E attendances. The safeguarding lead described to us how they used information supplied from the local A&E department to identify those children most at risk and the actions they took to support these children. This included weekly meetings with the Health Visitor for the practice, calling children and their parents in for a discussion about their health needs and appropriate follow up of children following their discharge from hospital. We saw that the practice had audited and risk assessed its processes for identifying and dealing with child protection concerns. Where they had identified potential gaps in their systems, actions plans had been put in place. For example, a system had been introduced to ensure that all relevant professionals were informed in a timely manner if a woman whose existing or previous children had been subject to a child protection plan had become pregnant.

The practice provided primary medical services for patients with learning disabilities living in a low risk independent mental health hospital. The safeguarding lead for vulnerable adults described to us how they attended multi-disciplinary meetings at the hospital to support these patients. They also acted as an advocate for these patients and were able to demonstrate training and knowledge of the Mental Capacity Act 2005 and Deprivation of Liberties. There are occasions when a service needs to protect people from harm by preventing them from undertaking certain activities. This is a deliberate deprivation of the person's liberty and there are clear guidelines to follow to ensure that all decisions are made in a person's best interests.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy ensuring medicines were kept at the required temperatures. Practice staff were aware of the action to take if the fridge temperature range was not maintained. However, measures had not been put in place, such as installing a switchless socket or clearly labelling the vaccine fridge plug with a cautionary notice, to prevent the accidental interruption of the electricity supply to the vaccine fridges.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that medicines used in the practice were in date. There was also a system in place for checking the medicines GPs carried in their doctor's bag when carrying out home visits.

We saw that there were systems in place to review prescribing in nursing homes, repeat prescribing and monitoring of prescribing for antibiotics. For example, we looked at the 'North Staffordshire Quality and Performance Report' and saw that the practice had been below the Clinical Commissioning Group's (CCG) annual antibiotic prescribing rate for the last three years.

We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up to date copies of most of the vaccines delivered by nurses however the PGDs for childhood vaccinations had expired in October 2014. The

practice was aware of this and we saw emails that confirmed they were in the process of updating these. At the end of the inspection we were provided with copies of the updated PGDs for staff and managers to sign.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs and had in place standard operating procedures that set out how they were managed. These standard operating procedures had recently been updated in response to a recent dispensing error and were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We saw that there were appropriate arrangements in place for the destruction of controlled drugs.

The practice offered a dispensary service for patients who did not live within one mile of their nearest pharmacy. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. Dispensing staff at the practice told us that all prescriptions were signed by a GP before being dispensed. If they were not signed, they would not dispense the medicines. Recent changes to the standard operating procedures for the management of controlled drugs now require there to be two qualified dispensers and a GP partner present when controlled drugs are dispensed. Staff we spoke with were aware of this change.

The practice had a system in place to assess the quality of their dispensing service. This included patient satisfaction surveys; training updates for staff; responding to and acting on complaints and incidents and monitoring and responding to alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA).

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. There were cleaning schedules in place informing the external cleaner what actions needed to be taken to keep the practice clean. However, there were no cleaning records that monitored these actions had been carried out on a daily basis. We also saw that the cleaning schedule did not include the actions the cleaner should take to prevent the occurrence of legionella (a bacterium found in the environment which can contaminate water systems in buildings) as described in the practice's risk log.

The practice had a lead for infection control and an infection control policy for staff to refer to. We saw evidence that infection control audits had been carried out and that any improvements identified for action were completed on time. Issues identified were discussed at staff meetings and a member of the nursing team described to us recent changes that had taken place to address issues identified.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that appropriate staff had received the relevant immunisations and support to manage the risks of health care associated infections

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as a defibrillator (a portable electronic device that diagnoses life threatening irregularities of the heart and is able to deliver a shock to attempt to correct the irregularity) was available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly

and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales

Staffing and recruitment

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so considered fit to practice. There was a system in place to monitor health professionals' registrations were in date. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service DBS. We saw that the practice had carried out an audit of their recruitment procedures to ensure that all staff had the necessary documentation and checks. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that the policy met legal requirements.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager showed us a needs analysis and risk assessment they had carried out when deciding and reviewing adequate staffing levels at the practice. We saw that this identified optimum staffing levels and actions to be taken if these staffing levels were affected. For example, we saw that due to the increase in the practice's patient population, a salaried GP had been employed in August 2014 to meet this need.

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.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

The GPs carried out weekly ward rounds for patients who lived in a local care home. This enabled them to identify risks to older patients who had a deterioration in their health. Staff at the care home told us that the GPs always responded quickly to any requests for an urgent visit and that all the patients aged 75 and above had a named GP and care plan in place to ensure continuity of care.

One of the male GP partners carried out weekly ward rounds at the independent mental health hospital for patients with learning disabilities. This enabled the practice to identify risks to these patients if they had a deterioration in their physical health. We spoke with a representative for the hospital who informed us that the practice was responsive to patients' needs and if a patient's physical health deteriorated, the practice were easily accessible and supportive. The practice was aware of the needs of female patients who may request to see a female GP. Following a risk assessment, systems had been put in place to support female patients from the hospital to be seen by a female doctor at the practice.

There were emergency processes in place for identifying acutely ill children and young people and children were provided with on the day appointments when needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator. All the staff we spoke with knew the location of this equipment. Records we saw confirmed that the defibrillator was checked on a monthly basis to ensure it was fit for purpose. However, there were no formal checks in place to ensure that the oxygen was in date and fit for purpose.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all the staff knew of their location. These included those for the treatment of anaphylactic shock (a sudden allergic reaction that can result in rapid collapse and death if not treated). Staff told us that if they needed other emergency medicines, such as for the management of low blood sugar or cardiac arrest, they obtained medicines from the dispensary. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in the process of being developed to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of domestic services, flood, staff shortages and IT failure.

A fire risk assessment had been completed that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with clearly outlined the rationale for their approach to care and treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. One of the GP partners and a GP registrar told us that guidelines were discussed at the weekly and monthly clinical meetings and required actions agreed. We saw minutes that confirmed this. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The staff we spoke with, and the evidence we reviewed, confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. The practice also worked with the GP registrars and medical students to ensure they were aware of the importance of NICE guidelines. One of the GP registrars we spoke with on the day of our inspection confirmed this.

The GP partners told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The GPs held weekly clinical meetings to discuss the needs of patients.

One of the GP partners showed us the practice's report from the local Clinical Commissioning Group (CCG) which benchmarked the service provided by all the practices within North Staffordshire. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar practices in the region. We saw that the practice's performance for antibiotic prescribing was below the CCG average.

The practice had a system in place to monitor the appropriateness and quality of patient referrals to other services. This included monthly in house GP referral management meetings and bi-monthly locality meetings and a yearly engagement meeting with the CCG to discuss referrals to the local A&E department. We saw three audits that confirmed this. All the GPs we spoke with followed national standards for the referral of patients with suspected cancer so that they would be seen within two weeks. Through the use of a nationally recognised cancer monitoring tool, in house referral audits and analysis of their cancer register, the practice had identified they were a high user of this referral pathway. We saw that the practice had carried out a clinical audit to understand why they were a high user of the system, if the referrals made had been appropriate and if there was any action they needed to take. We saw that the practice had put action plans in place to improve the appropriateness of their referrals. We looked at the most up to date local CCG benchmarking data and saw that the changes made had been effective because their referral rate was now in line with other practices within the CCG.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicine alerts. The information staff collected was collated by the GP partners to support the practice to carry out clinical audits.

The practice showed us ten clinical audits that had been undertaken in the last two years. Four of these were completed audits where the practice was able to demonstrate the changes that had resulted since the initial audit had been carried out. The GP partners told us, and we saw evidence, that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw that an audit had been carried out on the dosage prescribed to patients for a medicine used for the treatment of high blood cholesterol. Following changes suggested in the first audit, a second audit had been carried out which demonstrated that there had been improvements in the prescribing of this medicine. Other examples included audits to confirm that NICE guidelines were being followed for the administration of medicines to prevent a lack of vitamin D in at risk groups such as pregnant and breast feeding mothers.

The practice recognised the specific needs of their teenage patients and held an annual 'teenage birthday clinic' for children aged 14 to 15 years. Teenagers were offered individual health reviews which included a health

Good

Are services effective?

(for example, treatment is effective)

assessment and life style advice such as contraception or weight management advice. We saw that the practice nurse had audited the services that the practice provided which demonstrated improved health outcomes for patients. For example, we saw that the clinics had identified eight patients who were overweight. One of the teenagers had engaged with the weight management programme held at the practice and had lost 10.5KG over a three month period. The audit also demonstrated that as a result of the teenage health assessment, sexual health advice and the provision of contraception had been provided to patients to prevent unwanted pregnancies. Recommendations were made within the audit to improve the service offered.

The practice employed an elderly care facilitator to assess and help to manage risks to patients aged over 85 in their own home. We saw that the practice had carried out two audits to assess the effectiveness of these visits. The first audit demonstrated that 21 patients had successfully been supported to receive the attendance allowance. This could be used for such things as cleaning, ironing, shopping and gardening and supported older patients to remain in their own homes. A second audit demonstrated an increase in the identification of the number of patients with dementia. Referral rates to the memory clinic had been increased to improve the health outcomes for these patients. The practice had also carried out patient surveys of patients who had received this service. They had received 66 replies to this which demonstrated patient satisfaction was overwhelmingly positive. We saw that the practice used the feedback from patients to develop this service further.

The practice also used the information collected for the QOF against national screening programmes to monitor outcomes for patients. We saw that the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (COPD is a lung disease). The QOF data showed that the percentage of patients with atrial fibrillation (an irregular heart rhythm) who were provided with the appropriate medication was lower than the national average. We saw that the practice had carried out an audit to identify patients who needed this medication and that their treatment had been reviewed and changed if necessary. We saw from the CCG benchmarking data that following these changes, 98% of eligible patients now received this treatment. This was above the regional CCG average and in line with the national QOF data.

The practice had achieved and implemented the gold standards framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. There were 32 patients on the practice's end of life register. To ensure that patients received effective care and treatment the practice met weekly with the district nurses and bimonthly with the palliative care nurses to discuss the care and support patients and their families needed. We saw minutes from meetings confirming this.

Effective staffing

Practice staff included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training that the practice had identified as essential for staff. All GPs were up to date with their yearly continuing professional development requirements and all 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one of the practice nurses had recently completed formal training in managing minor injuries to support patients to be seen at the practice rather than the A&E department. Nursing staff received clinical supervision and GPs held weekly clinical meetings to enable them to reflect on the care they provided to patients.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines, cervical screening and the management of patients with diabetes, asthma and COPD. Those with extended roles such as prescribing told us that they received annual prescribing updates and supervision from the GPs. We saw evidence that the prescribing updates had been attended.

Working with colleagues and other services

The practice worked with other service providers to meet the needs of patients and manage complex cases. It received blood test results, X ray results, and letters from

Good

Are services effective?

(for example, treatment is effective)

the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice staff we spoke with understood their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required.

The practice held weekly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children and vulnerable adults. These meetings were attended by district and palliative care nurses and Health Visitors. We spoke with one of the Health Visitors who worked at the practice and they confirmed that these meetings took place. They told us that the GPs were supportive and communicated well and shared information of concern.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. A Health visitor described to us how they were working with the practice to improve the sharing of information in such areas as informing the Health Visitors when a new child registered with the practice so that they received appropriate care and support.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, EMIS web, to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's effectiveness.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice provided primary medical services for patients with learning disabilities living in a low risk independent mental health hospital. The safeguarding lead for vulnerable adults described to us how they acted as an advocate for these patients and were able to demonstrate training and knowledge of the Mental Capacity Act 2005 and Deprivation of Liberties in the safeguarding of vulnerable adults. There are occasions when a service needs to protect people from harm by preventing them from undertaking certain activities. This is a deliberate deprivation of the person's liberty and there are clear guidelines to follow to ensure that all decisions are made in a person's best interests.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually and we saw from QOF data that 98% of patients diagnosed with dementia had received an annual review. This was above the national average. When interviewed, staff gave examples of how a patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. Gillick competence is used to help to assess if a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, patients signed consent forms which were scanned into their care records.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients who registered with the practice. If a patient was on medication, they were seen by the GP first to enable a medication review to be carried out. The health care assistant showed us the template they used to carry out the health assessment. This included a health check and lifestyle advice. The GP was informed of all health concerns detected and these were followed up in a timely way. Patients were signposted to other services if needed, for example, smoking cessation and weight management.

The practice offered several health promotion and prevention clinics which included alcohol reduction, smoking cessation, weight management, cervical screening, travel vaccinations and childhood immunisations. We looked at data supplied by NHS England and saw that childhood immunisation uptake was in line with the CCG regional average.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. We saw from the CCG benchmarking tool that there was an 80% cervical screening rate and a 72%

Good

Are services effective?

(for example, treatment is effective)

seasonal 'flu uptake which were in line with the CCG average. Eighty-five per cent of patients with chronic heart disease had received cholesterol monitoring which was above the CCG regional average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 111 replies to the national patient survey published in January 2015 and a survey of 62 patients undertaken by the practice and their virtual patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 95% of respondents said that their overall experience was good or very good and 93% of respondents would recommend the practice to someone new in the area. These results were above the regional Clinical Commissioning Group (CCG) average. The practice was also above the CCG regional average for its satisfaction scores on consultations with doctors and nurses. Ninety-five per cent of respondents said the GP was good at listening to them and 92% said the GP gave them enough time. Ninety-seven per cent of respondents found the receptionists at this practice helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and all of the comment cards were very positive about the service experienced. Patients used words such as 'excellent' and 'fantastic' to describe the overall service and described staff as caring, compassionate, professional and kind. They said staff always treated them with dignity and respect. We also spoke with 18 patients on the day of our inspection. All of the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patient confidentiality at the reception desk was maintained by a queuing system. A notice informed patients to stand back from the reception desk and patients were offered a private room to discuss confidential matters. The switchboard was located in a separate office away from the reception area so that patient telephone conversations could not be overheard. Patients we spoke with on the day of our inspection confirmed that they had never overheard confidential information being discussed in the reception area.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We observed that patients were treated equally irrespective of their age, culture or appearance.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed that 91% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in the decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Data from the

Good

Are services caring?

national patient survey supported these findings with 95% of respondents saying that the last GP they saw or spoke to was good at listening to them and a 97% satisfaction rate for nurses.

The practice provided care and treatment for patients living in a local care home. A representative from the home told us that the practice had completed care plans for all the older patients living at the home. They told us that if patients had 'Do not attempt resuscitation' (DNAR) decisions in place, patients and their relatives had been involved in these decisions. They told us DNARs were reviewed three to six monthly by the GPs to ensure they accurately reflected patients' wishes. When a person does not wish to be resuscitated in the event of severe illness a 'Do not attempt resuscitation' form is completed to record this in their records to protect them from the risk of receiving inappropriate treatment.

There were 44 patients on the practice's learning disabilities register. We saw that all these patients had received an annual health review to ensure a systematic review of their health and medication. There were 26 patients on the practices' register for patients experiencing poor mental health and 99 patients on the practice's register for patients with dementia. There was a system in place to ensure that patients experiencing poor mental health received an annual health review either at the practice or at the local independent mental health hospital. Housebound patients with dementia were provided with a home visit to enable them to receive an annual health review.

The staff told us that there was a recall system for patients with long term conditions, such as diabetes or high blood pressure to receive an annual review of their health and wellbeing.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, respondents said the last GP or nurse they saw or spoke to was good at treating them with care and concern with a rate of 95 % satisfaction for GPs and 99% for nurses. These results were above the CCG regional average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, patient newsletter and patient website told patients how to access a number of support groups and organisations. The elderly care facilitator also worked closely with other agencies to support older patients and reduce social isolation. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. This was also available at the reception desk.

The practice followed the gold standard framework (GSF) for terminally ill patients. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. The GPs told us that if a patient was very near the end of their life they visited them twice daily if necessary. Although the practice did not provide a routine out of hours service, the GPs provided their contact details to the relatives of these patients so they could contact them at any time. The GPs told us that when a patient died they provided a home visit to the relatives if they wanted one. Staff we spoke with who worked at the practice confirmed that they did. Two patients we spoke with on the day of our inspection told us how supportive the GPs had been following the death of their close relative.

Outstanding ☆

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 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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. We saw that an audit had been completed by the practice to determine the level of undiagnosed dementia in their practice population. Data was collected as part of the locality over 75 project which included actions such as offering patients aged over 85 years a home visit and tests for memory loss. The dementia audit remained ongoing but proposals to improve the diagnosis of dementia and improved medical and social care have been made. The practice had submitted an application to the CCG for Innovation funding to develop a community based dementia diagnosis service. This would include a joint project with AGE UK supporting the benefits claims for older people plus a weekly psychogeriatrician clinic at the practice. A psychogeriatrician is a psychiatrist who specialises in behavioural and emotional disorders of older people.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient survey. For example, automatic doors had been installed at the entrance to the practice to assist patients with mobility difficulties.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had initiated positive service improvements for its patients. To meet the needs of patients whose circumstances may make them vulnerable, the practice had identified a lead GP for patients with learning disabilities and patients experiencing poor mental health. Patients with learning disabilities were offered an annual health assessment and the lead GP provided weekly ward rounds for patients with learning difficulties experiencing poor mental health at the local independent mental health hospital. The practice also facilitated legal support for patients in vulnerable circumstances. For example, the Citizens Advice Bureau visited the practice twice a month to support any patient in need of legal support. All patients over age 85 plus patients over age 75 who had been assessed as at risk, were provided with home visits from the elderly care facilitator employed by the practice. The elderly care facilitator aimed to identify and support older patients in areas such as falls prevention, benefit claims and to reduce social isolation. The practice did not have any homeless patients registered with them but told us that they would provide appropriate care and treatment if the need arose.

The practice recognised the specific needs of their teenage patients and held an annual 'teenage birthday clinic' for children aged 14 to 15 years. Teenagers were offered individual health reviews which included a health assessment and life style advice such as contraception or weight management advice. Teenage appointments were also available at the end of the day to enable them to access appointments outside of school hours.

We saw that the premises and services met the needs of patients with disabilities such as hearing and mobility difficulties. There was disabled parking available, step free access to the electronic entrance doors and provided toilets suitable for patients with restricted mobility, including those using a wheelchair. The practice was mainly situated on the ground floor of the building with easy access to the reception area. There was one consultation room on the first floor and patients were informed that if they had mobility difficulties they would be seen on the ground floor. We saw a notice was clearly displayed at the bottom of the stairs informing patients about this. We saw that the waiting area was large enough to accommodate patients with wheelchairs or prams and allowed for easy access to the treatment and consultation rooms. We saw there were baby changing facilities and that breast feeding mothers were offered a private room in which to feed their babies.

The practice provided equality and diversity training for all staff. We saw that the practice had identified equality and diversity training as part of their essential training for staff and that all staff had completed this. The practice

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

population were mainly English speaking but for patients whose first language was not English, staff had access to a telephone translation service to ensure patients were involved in decisions about their care.

Access to the service

Patients could book appointments on line or over the telephone four weeks in advance. Appointments were available at the Madeley Surgery weekdays from 8.30am until 6pm except on Thursdays when the practice closed at 1pm. There were extended opening hours to accommodate working age patients and school children until 8pm on Monday evenings. The practice also opened on Saturday mornings as part of the CCG initiative to reduce pressure on winter hospital beds and the A&E department throughout the winter months. Appointments at the practice's branch practice, Baldwins Gate Surgery, were available 9am until 12pm Monday to Friday.

Comprehensive information was available to patients about appointments on the practice website, in the reception area and in the patient leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. When the practice was closed patients were asked to call 111 to access the out of hours service provided by NHS111 and Staffordshire Doctors Urgent Care (Thursday afternoons only). In addition to this, GPs provided relatives of patients very close to the end of their lives with their contact details so that they received continuity of care.

Patients were generally satisfied with the appointments system once they got through on the telephone. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. Data from the national patient's survey demonstrated that 71% of patients found it easy getting through on the telephone to book an appointment which was below the CCG regional average of 75%. Some patients told us they found it easier to go into the practice to book an appointment face to face. However, 98% of respondents were able to get an appointment to see or speak to someone the last time they tried.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The practice had received 19 complaints during 2014. We tracked three of the complaints and found they had all been reviewed and analysed in a timely way and that there was openness and transparency in dealing with the complaint. Where learning had been identified we saw that action plans had been put in place and shared with staff at team meetings. We saw minutes of meetings that confirmed this. The practice had not reviewed complaints annually to detect themes or trends, however, lessons learnt from individual complaints had been acted on.

We saw that information was available to help patients understand the complaints system. Information on how to complain was displayed in the waiting room, in the patient leaflet and on the practice's website. The practice survey showed that 85 % of patients said they knew how to make a complaint if they needed to.

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 vision to deliver high quality care and promote good outcomes for patients. The organisational vision was documented in the staff appraisal forms and stated, 'We will deliver personalised care of the highest quality, with the best possible outcomes for users and carers, empowering them to remain independent'. The practice's values included, be innovative and adaptable, be respectful and caring of people and be honest, transparent and accountable. We saw that the staff and the culture within the practice strongly demonstrated the vision and values however staff were not aware of the formal vision statement. Although patients were not made aware of the vision statement, we saw that patients were informed of the level of service they had the right to expect via the practice leaflet. We saw that these rights were based on the practices' values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available for staff via the practice's computer system. We looked at 11 of these policies and saw that they had been reviewed at regular intervals and were up to date.

The practice held weekly business meetings and an annual planning meeting to discuss governance issues. The practice used a standardised agenda which included such items as significant events, complaints, finance and staffing issues. Minutes of the meetings were available on the practice's computer system and we saw minutes confirming this. Regular staff meetings took place where information was shared with partners and other staff groups. We looked at minutes from the meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a national performance measurement tool. The QOF data for this practice showed it was performing above national standards by obtaining 99.8 QOF points out a possible 100. We saw that QOF data was regularly discussed at partners' meetings and action plans were produced to maintain or improve outcomes.

The practice used clinical audits to monitor quality and to identify if action was required to improve outcomes for patients. The practice had completed a number of clinical audits, for example, audits to monitor that guidance for the administration of certain medicines for at risk groups was followed correctly. We saw that an audit had been completed which identified issues around following the guidance. We saw that changes and recommendations were made to ensure the guidance was followed. Following a re-audit we saw that improvements had been made with adherence to the guidance so that patient outcomes were improved.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as loss of domestic services or information technology; fire safety; buildings maintenance; access to appointments and prevention of the legionella virus. We saw that when risks had been identified, that action plans had been put in place and discussed at staff meetings.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example there was a lead nurse for infection control and lead GPs for safeguarding children and safeguarding vulnerable adults. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. They told us there was a no blame culture within the practice and openness and transparency were encouraged through team meetings and appraisal.

We saw from minutes that team meetings were held monthly for clinical staff and quarterly for non-clinical staff. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and information governance which were in place to support staff. Staff showed us how they accessed these policies if they needed to refer to them. The practice had a whistle blowing policy which was available to all staff via the computer system. Whistle blowing occurs when an internal member of staff reveals

Are services well-led?

Good

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

concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. We looked at the results of the annual patient survey which had focused on patient awareness of the practices' services and how to access to them. We saw that action plans had been put in place to raise awareness of access to some areas of the service that patients were unaware of or unclear about. For example, plans had been put in place to produce a card with the practice opening times on so that patients could pin it to their notice boards or keep by their telephone.

The practice had a virtual patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The virtual PPG enabled patients to share their views about the practice electronically. The practice manager told us that they were in the process of establishing a PPG that would include a cross section of patients from the practice and would meet at regular intervals to discuss and improve the quality of the service. We saw that adverts encouraging patients to join the PPG were on the practice's website and in the practice's newsletter.

The practice had 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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The practice had completed a practice development plan for 2014/2015. This included areas to be reviewed, issues associated with that area, who the lead for the area was and the outcome of changes made. For example, we saw that a named GP was the lead for the development of the current nursing team. We saw that there was an analysis of the support in place for the nurses and additional training identified or put in place to support nurses to provide services. This included the management of minor injuries and prescribing.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice manager had developed a training matrix which highlighted when staff training was due. We saw that all staff training was up to date. We looked in three staff files and saw that training certificates corresponded with the training matrix.

The practice was a GP training practice for GP Registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students. All three GP partners and a salaried GP were responsible for the induction and overseeing of the training for GP Registrars and medical students. The ethos of learning and improvement in terms of knowledge and skills was evident throughout the inspection. We spoke with a GP registrar on the day of our inspection. They told us that the GP partners were very helpful, positive and enthusiastic and that the partners promoted team work by using 'we' rather than 'I'. There was a buddying system in place to support GP registrars that provided them with a named GP who they had direct access to for advice and support.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and through emails to ensure the practice improved outcomes for patients. For example, appropriate staff informed us of the changes in practice that had been made following a recent dispensing error.