

Golden Valley Practice

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 22 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances 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 incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events over time.

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 safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Good



Are services caring?

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views from the manager of a care home where patients were registered with the practice were very positive and aligned with our findings.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient surveys and from the patient participation group (PPG). A PPG is usually made up of a group of patient volunteers and members of a

Good



Summary of findings

GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. The practice reviewed the needs of its local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments 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.

Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. The practice carried out proactive succession planning.

There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients through a patient participation group (PPG). A PPG consists of patient volunteers who share their views and respond to surveys through the practice's website. They comment about the services offered and how improvements can be made to benefit the practice and its patients.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. For example, we saw that the practice worked in a multi-disciplinary way to provide palliative care for patients. We saw that regular multi-agency and cross practice meetings were held and recorded.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

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.

Good



Families, children and young people

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 accident and emergency (A&E) attendances. Immunisation rates were relatively 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 and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

The practice had committed to take part in a new government funded initiative being developed within the county of Herefordshire. This initiative worked to provide additional extended hours for patients, in addition to the out of hours service, through the use of an agency. The agency used Golden Valley Practice premises to provide this service to patients during evenings and at weekends

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had carried out annual health checks and offered longer appointments for patients with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had advised vulnerable patients about how to access various support groups and voluntary organisations. 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). People experiencing poor mental health had received an annual physical health check. 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.

Summary of findings

The practice had advised patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND. 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.

Summary of findings

What people who use the service say

We reviewed the 43 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that 42 of these comments were extremely positive. Patients commented that they were impressed with the practice and that they could always see a GP or a nurse when they needed to. Patients told us that they could not praise all the staff at the practice highly enough and that all staff were courteous, happy and polite. Patients who had recently registered with the practice commented that they had never experienced such excellent care in all their life.

One patient indicated that they had found their experiences at the practice less positive. They commented that they thought the practice was excellent but felt the process for collecting prescriptions could be improved.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. The comments confirmed that GPs were always helpful and that they listened to concerns. Patients commented they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

We looked at the national GP Patient Survey dated July 2014 and found that patients were generally satisfied with the appointments system. Data showed that 75% were satisfied with appointment times; 87% described their experience of making an appointment as good; and 85% would recommend this practice to someone new to the area. All these results were above the national average.

Golden Valley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP specialist advisor. The team also included another CQC inspector and an Expert by Experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Golden Valley Practice

Golden Valley Practice is located in Ewyas Harold near Hereford and provides primary medical services to patients. Golden Valley has a branch surgery at Peterchurch but we did not inspect the branch surgery at this time. Golden Valley Surgery has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice covers a mostly rural area 13 miles west of the City of Hereford, which includes Dorstone, Craswell, Pandy and Orcop. The practice has a dispensary.

The practice has three male and one female GPs, a practice manager, an office manager, two practice nurses, a dispensary manager, three healthcare assistants, as well as administrative and reception staff. There were 5846 patients registered with the practice at the time of the inspection. The practice is open from 8am to 6pm Monday to Friday. Home visits are available for patients who are too ill to attend the practice for appointments.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as disease management clinics which includes

asthma, diabetes, heart disease and stroke, chest, and mental illness. It offers child immunisations, family planning, minor surgery, smoking cessation and well person clinics. Practice nurses can be seen by appointment for blood tests, blood pressure tests, and new patient checks. Visiting healthcare staff such as health visitors and community psychiatric nurses sees patients at both Golden Valley and their branch surgery. The practice does not provide an out of hours service but has alternative arrangements in place 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 was 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.

This provider had not been inspected before and that was why we included them.

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

Before our inspection of Golden Valley Surgery, we reviewed a range of information we held about this practice

Detailed findings

and asked other organisations to share what they knew. We contacted Herefordshire Clinical Commissioning Group (CCG) and the NHS England local area team (LAT) to consider any information they held about the practice. We spoke with the manager of a care home where patients lived who were registered with the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 22 October 2014. During our inspection we spoke with a range of staff that included three GPs, the practice manager, the dispensary manager, a nurse, two health care assistants and two reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We reviewed 43 comment cards where patients and members of the public shared their views and experiences of the practice.

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

- 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable

People experiencing poor mental health

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 as well as comments and complaints received from patients. Staff told us they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that significant events had been discussed at practice meetings over the last year which demonstrated the willingness by the practice to report and record incidents.

We reviewed safety records and incident reports for the past two years. This showed that the practice had managed these consistently over time and could evidence a safe track record over the longer term. We found that the practice had a standard form for recording incidents and staff demonstrated the ease of access they had to this should they need it. Staff made it clear they would feel confident to report any concerns. For example, a member of staff told us about an incident that had occurred from the way they had used a piece of equipment, which they had reported. This had been escalated and discussed at a team meeting where lessons learnt were shared with staff at the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last two years and were able to review these.

We found that significant events had been recorded. Details showed who had reported these events and the date for review or follow up on progress had been recorded, with details of action taken where completed. For example, we saw where an incident had occurred with a patient who had been prescribed a specific medicine and needed to be monitored regularly for this. This patient had not been called to attend the clinic as often as they should have done. We saw that action had been taken and that arrangements had been made to ensure regular monitoring was carried out. Alerts had been added to the patient's notes so that follow up calls could be made should the patient fail to attend.

Significant event discussions were a standing item on the weekly practice meeting agenda. We saw evidence from a meeting held on 1 October 2014 that confirmed significant events had been discussed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Reception staff told us they would report incidents when they occurred to their manager, who would then escalate these.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by the practice dispensary manager by email to practice staff. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and clinical meetings. This ensured everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that where action had been taken it had been recorded appropriately.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding adults and children. We asked clinical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for relevant agencies were easily accessible to staff.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to the appropriate level, and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures. Staff told us there was a separate folder with all policies and procedures kept in reception, and that all staff had a copy of these which they had signed to say they had read. We saw this folder was in place and contained an up to date policy with

Are services safe?

guidance for staff to follow to ensure adults and children were safeguarded. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm.

Patients' individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. We saw that the system was used to highlight vulnerable patients and ensured that staff were alerted to any relevant issues when patients attended appointments. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated effective working relationships with partner agencies such as health visitors, the police and social services.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Staff told us that chaperone duties were carried out by clinical staff and administrative staff. We were told by staff that they had completed chaperone training and records we saw confirmed this.

Medicines Management

We discussed medicine management with the dispensary manager. We saw that the practice had policies and procedures in place for the management of medicines dated September 2014. This included safe stock control, dispensing medicines to patient and disposal and safe storage of vaccines. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. We checked with the dispensary manager how repeat prescriptions were managed. We found that prescriptions were produced electronically and arrangements were in place for the GP to sign these weekly, with the exception of acute prescriptions which were signed at the time of issue.

Dispensing Doctors Association (DDA) guidance advises that prescriptions should be signed before they are dispensed. If prescriptions were not signed before they were dispensed a practice should risk assess this to demonstrate the process in place minimises risks. There had been times when patients had collected their repeat prescriptions before they had been signed by the GP. We asked to see a risk assessment to demonstrate that this process had been assessed and agreed within the practice. We found that no risk assessment had been done and that the policy for repeat prescribing had not considered GP signing protocols. The dispensary manager addressed this issue following our inspection and sent us copies of their revised protocol. They confirmed that the practice had robust systems in place with clear guidance for all staff to follow that considered potential risks to their operations.

We saw that blank prescription forms and prescription pads were tracked through the practice and kept securely at all times. The practice had a process in place to limit the number of repeat prescriptions to ensure that patients' medicines were regularly reviewed.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. The scheme required key elements from participants including that they were appropriately trained and undertook continued training with annual appraisals; and that regular audits with learning from these took place within the practice. We saw minutes of a meeting held in June 2014 where future audits to be completed to meet DSQS requirements had been discussed.

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These 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. There were arrangements in place for the destruction of controlled drugs.

The practice dispensary staff undertook regular audits of controlled drug prescribing to look for unusual products,

Are services safe?

quantities, dose, formulations and strength. Staff confirmed they were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. For example, we saw that directions for the administration of flu, tetanus and shingles vaccines had been signed by the nursing staff. Nurses we spoke with confirmed that training was provided to ensure they kept up to date with their clinical expertise, knowledge and skills. We saw training records that supported this.

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 in place for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff confirmed they understood and followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We saw from the comment cards that patients always found the practice clean and had no concerns about cleanliness or infection control. Hand hygiene technique signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw hand sanitation gel was available for staff and patients throughout the practice including the reception area.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example,

personal protective equipment including disposable gloves, aprons and coverings for couches were available for staff to use. Staff described to us how they used these in order to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training. We saw records that showed staff had received induction training about infection control specific to their role and received regular annual updates. We saw records that staff had completed infection control training during 2014 and staff we spoke with confirmed this.

We saw evidence that the infection control lead had carried out regular audits and that any improvements identified for action were completed on time. We saw that the most recent audit had been carried out during October 2014 and practice meeting minutes showed that the findings of this audit had been discussed. We also saw evidence that an external infection control audit had been carried out which detailed the findings and identified action required. For example, the infection control audit carried out by Herefordshire Clinical Commissioning Group (CCG) on 2 October 2014 showed an improved score of 88% compared to the previous year's audit of 84%. The practice team meeting held following this audit showed discussions had taken place on the need to conduct more regular internal audits, with proposals for every three months. We saw that an action plan had been put in place to address shortfalls in the CCG audit.

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. There were guidelines informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment rooms to guide staff in the event of injury.

We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections. For example, we saw records that showed staff had Hepatitis B immunity. Staff we spoke with confirmed that they kept their immunisations up to date.

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment available so they could carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that portable electrical equipment was clearly labelled and dated to show it had been tested in October 2013 by an external contractor.

We saw records that confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. We saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, nebulisers and blood pressure monitoring machines had been carried out during 2014.

Staffing & Recruitment

Recruitment and selection processes were in place to ensure that staff were suitable to work at the practice. We saw a policy which outlined the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice.

We saw that Disclosure and Barring Service (DBS) checks had been completed for all relevant staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. We looked at a sample of recruitment records for clinical and administrative staff. These showed that pre-employment checks had been done to ensure that clinical staff held up to date qualifications with their governing bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This ensured that GPs and nurses were registered with their appropriate professional body and were considered fit to practice.

We spoke with staff about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us that most of the team lived nearby so that if cover was needed urgently they would manage this between themselves. They told us this was how they had worked previously when there had been bad weather and access to the practice had been difficult for some staff.

Monitoring Safety & 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 medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy in place. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We saw that annual and monthly checks of the building and the environment were carried out. We looked at records that confirmed these checks took place.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they failed to attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should

Are services safe?

one occur. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Staff confirmed that any instances where emergencies had occurred would be discussed at the practice's significant event meetings. For example, staff told us about an incident where a patient had collapsed outside the building. We were told that all staff responded appropriately, with the relevant equipment, and had been confident to use this had it been necessary. The patient responded to assistance and had not needed emergency treatment.

We saw risk assessments had been completed for risks associated with spillages, contamination and disposal. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records

showed that staff were up to date with fire training and that they practised regular fire drills. We saw that the last fire drill had been done on 13 August 2014 and the fire risk assessment had been updated on 7 August 2014.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of an electrical company to contact in the event of failure of the electricity supply, and utility services such as heating and water suppliers. We saw there was an escalation procedure in place to protect computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to 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. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. 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.

GPs told us they each led in specialist clinical areas such as diabetes, joint injections, respiratory disease, heart disease, mental health, and dermatology (skin). The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

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

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and

Outcomes Framework (QOF). For example, we saw audits regarding the treatment of high blood pressure, and the long term use of antibiotic medicines. Following the audits, the GPs carried out medicine reviews for patients and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. We saw evidence that showed the findings of these audits had been discussed at practice meetings and actions taken had been recorded. Both these audit cycles had been completed. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. We saw examples of audits currently in progress such as monitoring of cholesterol levels in patients.

The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The practice nurse told us they had carried out cervical screening audits and these were reviewed by senior clinical staff. Clinical staff told us audits were done and were discussed at practice meetings. They gave examples of infection control and minor surgery infection audits. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement. Staff told us that they all worked together to achieve the best care for patients at all times and because the practice was small this meant they got to know their patients and were able to respond to their needs more effectively.

There was a protocol for repeat prescribing which was in line with national guidance. Staff confirmed that they followed this protocol. They told us they regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe this

Are services effective?

(for example, treatment is effective)

outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staff employed at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training in areas such as basic life support and safeguarding adults and children. A good skill mix was noted amongst the GPs. GPs had additional interests in areas such as diabetes, asthma, heart disease, palliative care, safeguarding, dermatology and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a more detailed assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We saw records that confirmed staff had received annual appraisals. We saw that action plans had documented each person's identified learning needs and future objectives had been set. Staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post.

The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results

was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which had not been followed up appropriately.

The practice held bi-monthly multidisciplinary team meetings to discuss the needs of complex patients, such as those with end of life care needs or children who were considered to be at risk of harm. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and told us this was an effective way of sharing important information.

We spoke with the manager from a care home whose patients were registered with the practice. They told us a GP visited patients regularly each week at the home. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (EMIS) was used by all staff to coordinate, document and manage patients' care. All staff were trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to hospital in an emergency. Patients registered with the practice had been encouraged to sign up to the electronic Summary Care Record. Information about this was available for patients on the practice website, with a form they could use to opt-out from having a Summary Care Record if they chose. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had committed to take part in a new government funded initiative being developed within the county of Herefordshire. This initiative worked to provide additional extended hours for patients, in addition to the

Are services effective?

(for example, treatment is effective)

out of hours service, through the use of an agency. We saw that information sharing protocols were in place such as the Data Sharing agreement dated 8 July 2014, for the agency who would provide extended hours for patients.

Consent to care and treatment

We saw that the practice had a policy on consent which included the principles of the Mental Capacity Act (2005), and information about the assessment of Gillick competency of children and young adults. Gillick competency helps clinicians to identify children under 16 years of age who have the capacity to consent to medical examination and treatment.

We found that training records had not included specific training on the Mental Capacity Act (2005). Staff confirmed they had not completed this training although they demonstrated an understanding of the key parts of the legislation and were able to describe how they implemented it in their practice. Staff described how they would respond if a patient attended with a carer or relative. They told us they would always speak with the patient and obtain their agreement for any treatment or intervention, and if they thought a patient lacked capacity, they would ask their GP to review them. GPs told us they had access to experts for any support that was needed, and they also had access to clinical protocols via the internet. We discussed this training with the practice manager who told us they would include Mental Capacity Act training in their programme for 2015.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that confirmed care plans were in place and that reviews had been carried out.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw copies of completed consent forms which confirmed the consent process for minor surgery had been followed. We spoke with clinical staff that assisted during minor surgery.

They described the procedures they followed and these included obtaining consent during the initial consultation with the patient. This was then reviewed when the patient attended for their minor surgery.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurses. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews, offering smoking cessation advice to smokers, or to review the patient's long term condition.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations. Where patients were identified as being 20% or more at risk they were eligible for referral to a Halo Healthy Lifestyles Intervention programme. Halo offered two programme options of either a healthy weight management programme or a more active lifestyle programme, and both programmes provided patients with gym and swimming passes.

The practice used numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify patients at risk such as those who were likely to be admitted to hospital and or patients receiving end of life care. These patient groups were offered further support in line with their needs.

Up to date care plans were in place that were shared with other providers such as the out of hours provider and with multidisciplinary case management teams. Patients aged

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(for example, treatment is effective)

75 or over and patients with long term conditions were provided with a named GP. Summary care reviews were provided by the practice for individual patients. This ensured that out of hours services and hospital services were able to access information about patients to assist in their treatment in the event of an emergency.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend by either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

Golden Valley Practice operated a patient carer protocol, to identify carers they could signpost to support agencies for help should they need it. We saw that a carer's register was maintained at the practice, with a protocol in place to identify potential carers at clinics. The practice had carer support information available for patients in the waiting room which gave contact details for Herefordshire Association of Carers support group.

The practice had committed to take part in a new government funded initiative being developed within the county of Herefordshire. This initiative worked to provide additional extended hours for patients, in addition to the out of hours service, through the use of an agency.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse.

The practice's performance for cervical smear uptake was 81%, which was better than the average of 78% for others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following up patients who did not attend screening. The practice's performance for other health promotion areas such as providing smoking cessation advice was 96% compared with the 93% average for others in the CCG area.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated July 2014 and a survey of patients undertaken by the practice in 2013. The evidence from all these sources showed patients were satisfied that they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 75% were satisfied with appointment times which was less than national average of 80%; 87% described their experience of making an appointment as good compared with national average of 78%; and 85% would recommend this practice to someone new to the area which compared with national average of 79%.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 43 completed cards and all but one were positive about the service experienced. Patients commented that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They noted that staff treated them well, politely and with respect. One patient indicated that they had found their experiences at the practice less positive. They commented that they thought the practice was excellent but felt the process for collecting prescriptions could be improved.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff confirmed they ensured that each patient's dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Staff told us they made sure patients were as comfortable as possible during these times. Patients told us on the comment cards that their dignity was respected when they needed an examination.

Staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was

made available to patients to inform them that a chaperone option was available to them. We saw leaflets in the reception area and information on the practice website that confirmed this.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us 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 manager or one of the GPs. Staff told us incidents would be investigated and this information and any learning would be shared with staff. We saw minutes of staff meetings that had taken place which showed that incidents had been discussed and learning identified.

We spoke with the manager of a care home where patients were registered with the practice. They described the caring, professional, supportive attitude of everyone who worked at the practice from GPs, to nursing and reception staff. They told us they had no hesitation in contacting the GPs should they need to and they confirmed that a GP would attend as required.

There was a clearly visible notice in the patient reception area and on the practice's website informing patients of their zero tolerance for abusive behaviour. Receptionists told us they felt confident in responding to such incidents and that referring to the procedure had helped them diffuse potentially difficult situations. Staff described one situation that had occurred and they had followed the procedure. They told us about the support and response received from other staff when they had called for help in managing this difficult situation. The situation had been successfully diffused and staff told us this had been discussed as a learning event at the following staff meeting.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their

Are services caring?

involvement in planning and making decisions. For example, data from the national patient survey 2014 showed 88% of practice respondents said the GPs were good at involving them in decisions about their care which compared with 81% for the national average. The national patient survey 2014 showed 91% of practice respondents said the nurses were good at involving them in decisions about their care which compared with 85% for the national average.

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that patients were always encouraged to be involved in the decision making process. They told us that they would always speak with the patient and obtain their agreement for any treatment or intervention even if a patient attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. Staff told us that GPs gave their personal mobile telephone numbers to patients who were terminally ill so that they could be contacted outside of surgery hours if necessary.

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

Patient/carers support to cope emotionally with care and treatment

Comment cards completed by patients were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required. Patients commented that the staff had always been there for them and their family, and that they were very friendly and caring.

Notices in the patient waiting room and on the practice website also signposted people to a number of support groups and organisations. The computer system used by the practice 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.

We saw that regular multi-agency and cross practice meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives or carers in the waiting rooms and on the practice website. This included information to advise patients what to do if a death occurred at home or in hospital. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service. The manager of the care home told us that GPs always gave support where it was needed to patients who were registered with the practice.

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 people's 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. For example, GPs told us that their practice population consisted of mainly older, retired people who lived in the rural location. Attendance at Accident and Emergency departments at the local hospital was lower than other practices in the CCG area. The GPs told us this was because patients could always get an appointment and that the practice was closer and easier to get to than the local hospital.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. The practice used the Choose and Book referral system and told us that each patient left the practice with an appointment when a referral was required. This was because the secretarial staff organised this in conjunction with the patient and made the arrangements at the time. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

Longer appointments were available for patients who needed them such as patients with mental health, learning disabilities and long term conditions. Patients were also given appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. For example, the PPG action plan had requested that a chair was provided in the hallway to the waiting room, and that a suggestions box was made available in the waiting room. We saw that the practice had responded to this feedback and both the chair and the suggestions box had been provided.

Tackle inequity and promote equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for an interpreter if required and that information could also be translated via the internet.

A female GP worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties. The practice also provided a wheelchair for patients to use in the event they had difficulty getting into the practice waiting room.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it.

Are services responsive to people's needs?

(for example, to feedback?)

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

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8am to 6pm Monday to Friday. Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to a local care home on a specific day each week, by a named GP.

Patients who wanted an appointment later in the evening than 6pm or at weekends were told about a local extended hours government funded initiative provided by a federation of local GPs. This provided appointments between 6.30 and 8pm on weekdays and between 8am and 8pm at weekends. Receptionists at all GP practices locally had access to the appointment booking system and could book appointments direct for patients.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. We tracked two complaints and found these had been handled satisfactorily, in a timely way with learning identified where appropriate.

We saw that nine complaints had been logged for the previous 12 months. The letters of complaint had been received by the practice which indicated patients knew how to complain and all complaints were looked and actioned however serious or otherwise they were. For example, we saw where a complaint had been made by a patient who was unhappy because the brand of a medicine they were prescribed had been changed because they were no longer made by the manufacturer. We saw evidence that the practice had taken the time to explain to the patient the issues involved and discussed a suitable alternative medicine. The GPs showed they had responded to the patient's anxieties in a fair and supportive manner.

Accessible information was provided to help patients understand the complaints system on the practice's website and in the practice's leaflet. Staff told us that all new patients were given a booklet about the practice, which included information about the complaints procedure, when they registered with the practice. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever needed to make a complaint about the practice. Staff told us they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on.

Are services responsive to people's needs? (for example, to feedback?)

We saw that compliments received by practice had been kept. For example, we saw that an article in the local newspaper from a patient thanking the practice for their help and support.

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

We found that there had been some significant changes to the structure of the practice throughout 2014. This had been due to retirement of a GP partner and a long standing receptionist. Further changes were due to occur as another GP was due to leave the practice at the end of the week we inspected. There were plans in place to manage these changes and GPs had been recruited to the practice. The senior GP told us that nursing, reception and administrative staff had been stable throughout this time.

The aim of the practice was to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. GPs spoken with confirmed this. We spoke with six members of staff and they all demonstrated they understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with GPs who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and practice managers were very supportive.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at nine of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a scheme

which rewards practices for providing quality care and helps to fund further improvements. The QOF data for this practice showed it was performing in line with and above national standards. For example, data showed that the practice achieved a total 99.6% QOF points compared with the national average of 96% in 2013.

The practice had completed a number of clinical audits which included audits for medicines prescribed for mood disorders and medicines prescribed to prevent the loss of bone mass. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We found that the practice had robust 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 spillages. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks such as needle stick injuries.

Leadership, openness and transparency

There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. Following a period of significant change within the practice the GPs told us they were looking forward to the new team becoming established and settled. There was a practice manager and a business manager in post. The staff were organised into medical, nursing and reception teams. They operated as separate teams linked by managerial input.

Named members of staff had lead roles. For example, there were clinical leads for asthma, lung disease, chronic kidney disease, diabetes, women's health, cardiovascular (heart) medicine, minor surgery, dermatology (skin), palliative care and safeguarding. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by everyone at the practice.

Are services well-led?

Good 

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

Staff told us that there was a positive, open culture and focus on quality at the practice. Staff said they had the opportunity and felt comfortable about raising any issues at team meetings. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and practice manager were very supportive. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior partner was visible and accessible. Staff told us they were happy to work at the practice, that everyone worked well together and they were well looked after.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy, recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patients' surveys which had been completed during 2013/14 and from complaints received. The practice had a Patients Participation group (PPG) which was formed during 2013. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. There were 29 members of the PPG. At the time of the inspection the group had met three times, in which they discussed the results of the patient survey that had been completed at the beginning of 2014.

The practice had an active virtual patient participation group (PPG). This was available to all patients through the practice's website and provided the opportunity for them to complete questionnaires and give their views about the practice. Staff told us the practice shared the results with the whole team for discussion at their staff meetings. This gave staff the opportunity to give feedback on any of the findings from the survey report. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The results of the survey showed mainly positive comments with some negative comments about opening times and the car park arrangements. An action plan had been produced to address issues raised from the patients' survey. Priorities identified for action were to improve communication for patients who had little or no access to information on the practice's website. Patients who had not attended for appointments were less likely to see information made available to everyone in the waiting room. The practice planned to increase communication through local publications. Other actions identified which had been completed included the provision of a suggestion box in the waiting room and the provision of a chair in the hallway. We saw the chair and the suggestion box were in place during our inspection.

We saw from minutes that staff meetings usually took place every two months. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed they knew who to talk with in the event they had any concerns.

Management lead through learning & improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

Are services well-led?

Good 

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

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held in 1 October 2014. We saw that the details of the incident, who was involved, and action taken had been discussed.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with staff at practice meetings.