Belle Vale Medical 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Belle Vale Medical Practice on 28 April 2015. Overall the practice is rated as good.

Belle Vale Medical Practice provided safe, effective, responsive care that was well led and addressed the needs of the population it served. The service was caring and compassionate and patients spoke highly of it.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and carried out their responsibilities to raise concerns and report incidents and near misses. Lessons learnt from the investigation of safety incidents were disseminated to staff. Infection risks and medicines were managed safely.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Patients experienced clinical outcomes that were in line with or above the national average.
- Patients said they were treated with care, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice provided good care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately. Patients said the on line booking system had improved access to appointments. Most patients were satisfied with the opening hours, continuity of care and availability of appointments.
- There was a clear leadership structure, staff enjoyed working for the practice and felt well supported and

Summary of findings

valued. The practice monitored, evaluated and improved services. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held. This should include obtaining information about any physical or mental health conditions which are relevant to the person's role.

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 carried out their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding leads. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe. However we found that not all the relevant information required for workers was held on staff files.

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, including the Quality and Outcomes Framework (QOF). The practice had achieved high scores for QOF last year (97.9%, this was higher than the national average). Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older, vulnerable patients and those with long term and mental health conditions. Patient's 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. Appraisals and personal development plans were carried out for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were complimentary and positive about the service and the care and treatment they received. Information from the patient survey showed that patients rated the practice higher than others for several aspects of care. They said they were treated with care, compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed that staff treated patients with kindness and respect and maintained confidentiality. The practice was supportive of the emotional needs of patients.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. They engaged with NHS England Area Team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients who had a preferred GP said they did not always find it easy to make an appointment with them. The online bookings of appointments had improved access with appointments available the same day if needed and advance booking available for up to two weeks in advance. Information about how to complain was available and evidence showed that the practice responded appropriately to issues raised with learning and improvements implemented as a result.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and values for care. There was a clear leadership structure and staff felt supported by the management and the whole team. The practice had a number of policies and procedures to govern activity and held regular clinical, governance and team meetings. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group. Staff received inductions, regular performance development reviews and attended staff meetings and learning and development 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. For example the Quality and Outcomes Framework (QOF) information indicated that last year 78% of patients aged 65 and older had received a seasonal flu vaccination. This was higher than the national average. 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, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits, rapid access and extended appointments for those with enhanced needs.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than national average number of patients with long standing health conditions (63% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. The practice had engaged with Telehealth UK to promote self-care and management of conditions and to reduce unplanned hospital admissions. Telehealth is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis and monitoring typically used to support patients with Long Term Conditions. Among other things it comprises of fixed or mobile home units to measure and monitor temperatures, blood pressure and other vital signs parameters for clinical review at a remote location using phone lines or wireless technology

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease, asthma and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term

Summary of findings

health conditions received care and treatment as expected and above the national average. For example, patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations and patients with long term conditions had regular reviews of their health and medication.

Clinical staff managed chronic long term conditions and diseases. Patients at risk of hospital admission were identified as a priority. Longer appointments (for example 30 minute appointments) and home visits were available when needed. 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 social 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, the practice maintained a register of children who had a child protection plan. Immunisation rates were around average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies including breast feeding and baby changing rooms. We saw good examples of joint working with midwives, health visitors and school nurses. For example there were weekly health visitor clinics held at the practice.

The practice responded to the needs of this group well and children or young people were always given a same day appointment or urgent appointment as necessary. The practice safeguarding lead worked with the health visitor safeguarding lead to identify, discuss and care for children at risk.

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 offered flexibility in appointments with telephone consultations, online booking and other online services available for

this group of patients. They provided a range of services such as health promotion and screening that reflected the needs for this age group, for example smoking cessation and travel advice. Routine health checks were available to patients aged over 40.

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, children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments (30 minutes) for vulnerable patients. The practice contacted patients who had been discharged from hospital following an unplanned admission within 72 hours of their discharge.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

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). They held registers of patients experiencing poor mental health which helped them plan deliver and review care appropriately. One hundred percent of people experiencing poor mental health had an agreed documented care plan and 95% of those diagnosed with dementia had received a review of their care in the preceding 12 months. 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.

The practice worked closely with the mental health services in Liverpool. The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND and referred patients to the local memory clinic where appropriate. Patients with poor mental health were accommodated, where possible, with same day appointments with a preferred clinician. Home visits were made to accommodate patients who were not mentally well enough to attend the practice. Some of the 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

We spoke with 8 patients (including members of the patient participation group (PPG)) on the day of our inspection. We received 25 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions and carers.

All patients were positive about the practice, the staff and the service they received. They told us staff were kind, caring, and compassionate and that they were always treated with dignity and respect.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in July 2014 demonstrated they performed well with 97% of respondents saying they had confidence and trust in the last GP they saw or spoke with. Ninety four percent said the last GP they saw or spoke to was good at treating them with care and concern, 98% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety three percent said the last GP they spoke to or saw was good at listening to them, whilst 95% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing above average for the majority of questions asked.

We did not receive any concerns regarding accessing appointments on the day of inspection from patients we spoke with and the comments cards reviewed. However only 56% of patients responding to the National GP Patient Survey (2014) said it was easy to get through to the surgery by phone with 68% describing their experience of making an appointment as good. These results were lower than the national average. Patients from the PPG told us that the online booking and the new telephone system had greatly improved access to appointments.

Only 42% of respondents to the National GP Patient Survey (2014) with a preferred GP said they got to see or speak to that GP. This was also lower than the national average. This was confirmed by patients we spoke with on the day, saying they sometimes had difficulty getting an appointment with the GP they preferred, however were prepared to wait for an appointment in order to see that GP. They told us they were always offered an appointment with another GP if needed. All patients told us they were able to get an appointment or speak to a GP on the same day in the case of urgent need.

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held. This should include obtaining information about any physical or mental health conditions which are relevant to the person's role.

Belle Vale Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP specialist advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Belle Vale Medical Practice

Belle Vale Medical Practice is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 7500 patients living in Liverpool. The practice has six GPs (two male and four female), a practice manager, practice nurses, administration and reception staff. Belle Vale Medical Practice holds a Personal Medical Services (PMS) contract with NHS England.

The practice is open during the week; between 8.00am and 6.30pm. Patients can book appointments in person, online or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Liverpool Clinical Commissioning Group (CCG).The practice is situated in an area with high deprivation. The practice population is made up of a slightly higher than national average working age population. Sixty three percent of the patient population has a long standing health condition, whilst 51% have health related problems in daily life. There is a slightly lower than national average number of unemployed.

The Out-of-Hours GP service is provided by Urgent Care 24 (UC24).

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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?

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

Detailed findings

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GPs, practice nurses, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

Liverpool Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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 near misses. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

We looked at the records of significant events that had occurred during the previous 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff through discussions, meetings and via email. All staff knew how to raise issues and were encouraged to do so. The practice told us they carried out an overview of significant events every six months in order to identify themes or trends. We saw evidence of meetings at which a review of significant events and complaints was carried out.

The practice showed us the system used to manage and monitor incidents. We tracked some incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of documented action taken as a result and implementation of learning. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and is currently causing an epidemic in West Africa). We saw actions taken in response to the guidance. Staff also told us relevant alerts were discussed at team meetings or disseminated via email to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had up to date safeguarding child and adult policies and procedures in place. They provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were easily available to staff on the practice computers and in hard copy. Staff had access to contact details for both child protection and adult safeguarding teams. These were displayed in administrative and clinical rooms.

We looked at training records which showed that all staff had received relevant role specific training in safeguarding. Clinical staff had a higher level of training than other staff. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and how they were cared for.

The practice had a dedicated GP as lead in safeguarding supported by a deputy, the practice manager. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead was not always able to attend safeguarding conferences they were invited to, however they did complete all requested reports for child protection and serious case review meetings. All staff we spoke to were aware of the safeguarding lead. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

attended appointments; for example children subject to child protection plans. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed their care at regular clinical meetings.

The practice had a current chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and temperature sensitive medicines. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and clinical staff we spoke with had a clear understanding of the actions they needed to take to keep vaccines safe. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We noted that the fridges used to store vaccines and other medicines were not hard wired however they did have warning notices displayed to alert people not to inadvertently unplug them.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. We saw records and were told about actions taken in response to a review of prescribing and of patient medicines. Audits had been undertaken and improvements noted were evident.

There was a GP lead for prescribing and a prescribing policy, protocol and procedures that staff were aware of and followed. Prescription pads were stored securely and managed safely. The practice had recently moved to electronic prescribing and found this was efficient and safe. Medicines in doctors bags were appropriate and in date.

Medicines for use in medical emergencies were kept securely in the administrative area. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. The practice also had emergency medicine kits for anaphylaxis and meningitis.

The practice staff and GPs were supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team visited the practice, regular meetings were held with them and audits undertaken.

Cleanliness and infection control

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The treatment rooms, minor operations room, waiting areas and toilets were clean and well maintained. Staff had access to protective equipment such as gloves and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms, couches were washable and clean. Curtains were clean and were laundered six monthly or more frequently if needed.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Checks were carried out to ensure items such as instruments, gloves and hand gels were available and in date. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Infection control training was undertaken by all staff and was up to date. Staff understood their role in respect of preventing and controlling infection. For example, reception staff could describe the process for handling submitted specimens.

The practice had an infection control audit undertaken by the community infection control team in 2013. We saw the

Good

Are services safe?

outcome report with actions implemented. The practice had scored 99%. However we noted that no re audits had been undertaken by the practice since this to ensure standards were maintained.

Cleaning was carried out under contract by the premises management team and the cleaning standards and schedule were monitored.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw evidence of this displayed in clinical and treatment rooms.

The premises management team contracted regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw evidence that demonstrated this had been done recently.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw records that confirmed this. There were contracts in place for regular checks of fire extinguishers and portable appliance testing (PAT). All portable electrical equipment was routinely tested and displayed stickers indicating the last testing dates which were in date. We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers and blood pressure measuring devices.

Emergency equipment was stored in the administrative area. This included nebulisers, oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). They were maintained and checked regularly.

Staffing and recruitment

There was an up to date recruitment policy in place which was in line with current guidance.

We looked at five staff files including clinical and non-clinical staff and the most recently employed. We found that mostly all the required information relating to workers was available. We found that a Disclosure and Barring Service (DBS) check had been undertaken for all clinical staff and some non-clinical staff where this was appropriate (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). We found that the files were well organised and contained relevant and required information relating to workers. However we found that information was not held about any physical or mental health conditions which may be relevant to the person's role at the practice.

We were told that mostly clinical staff acted as a chaperone. Chaperone training had been undertaken by some reception and administrative staff who had also had a DBS check undertaken. They undertook chaperone duties only when clinical staff were not available.

There was no system in place to ensure clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) were monitored and checked regularly. We discussed this with the practice manager who told us they would implement a system to ensure these checks were maintained. On the day of inspection we saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

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

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 premises, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was

Good

Are services safe?

displayed for staff to see. There were identified health and safety representatives and fire marshals for the building. There were environmental and fire risk assessments in place that were monitored.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: ill children and young people were always given an appointment the same day and acutely unwell patients were responded to effectively when attending the practice.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. The document contained relevant contact details for staff to refer to. Staff we spoke with were aware of the business continuity plan.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert others to emergency situations. Staff told us they had received training in basic life support and they were able to demonstrate knowledge of what to do in an emergency situation, however the practice did not undertake medical emergency drills as part of their training. There was emergency equipment and medicines available including oxygen and an automated external defibrillator.

Suitable emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Records showed that fire fighting equipment and fire safety equipment (such as fire alarm) were routinely checked and maintained under contract. Staff were up to date with fire training, this included practising regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from discussions and documents we reviewed that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately. GPs and practice staff attended regular training and educational events provided by the Clinical Commissioning Group.

The GPs, practice manager and practice nurses told us that they met regularly to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions and those with poor mental health with external health and social care workers.

The GPs specialised and led in clinical areas such as safeguarding, minor operations, diabetes and coronary heart disease. They also specialised and took the lead with different patient groups such as women's health, mental health and vulnerable patients such as those with learning disabilities. The practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information. Older patients and those with long term conditions and mental health needs including dementia were well cared for by the practice. Care plans were in place for vulnerable older patients including those with poor mental health, learning disabilities and patients at risk of unplanned admission to hospital.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care homes, patients experiencing poor mental health and homeless patients. We found the management team were familiar with the needs of patients and the impact of the socio-economic environment. Services provided were tailored to meet these needs. The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital. We saw how these referrals were monitored and followed up to ensure an appointment was provided within two weeks.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved good scores for QOF over the last couple of years (last year they obtained 97.9%) which demonstrated they provided good effective care to patients. QOF information indicators demonstrated for example, the percentage of patients aged 65 and older and patients with diabetes who had received a seasonal flu vaccination were higher than the national average. QOF information also indicated that patients with long term health conditions received care and treatment as expected and above the national average including for example patients with diabetes had regular screening and monitoring and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Child immunisations rates were around the national average.

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 medicines management. The information staff collected was then collated by the practice manager to support the practice to improve care and to carry out clinical audits. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date registers for patients who were vulnerable and

Good

Are services effective?

(for example, treatment is effective)

for those with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). These registers were used to identify and monitor patients' health needs and to arrange health reviews.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included diabetes, citalopram prescribing, dermatological referrals, and audit of deaths in the over 75 age group. These were fully completed audits where the practice was able to demonstrate the changes resulting since the initial audit, improved patient outcomes and ensured the practice worked within NICE guidelines.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision, locality performance indicators and QOF. For example, the CCG pharmacy support team visit regularly and audited medicines management such as domperidone reviews and antibiotic prescribing. The practice was part of the Belle Vale Neighbourhood team of the CCG area. Local practices met regularly supported by the CCG and benchmarked their data and performance against other practices to encourage improvements.

The team was making use of clinical audit tools, clinical supervision, appraisals and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

One of the GPs took the lead for palliative care patients. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The patient's care plan and any other relevant information were shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction check list in place which identified the essential knowledge and skills needed for new employees. We saw completed induction checklists in staff files we looked at.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with core (mandatory) training such as safeguarding, cardio pulmonary resuscitation (CPR), fire safety, infection control and information governance. The practice manager kept a record of training carried out by all staff. They were implementing a new computer package which enabled easy management of core training for staff.

The practice manager monitored core training and ensured staff were kept up to date with essential and role relevant training needs. We noted a good skill mix among the doctors and nurses with each having special interests in different fields of general practice.

Staff undertook annual appraisals that identified learning needs from which action plans were documented. These were currently due to be undertaken for this year. We spoke to staff who told us the practice was supportive of their learning and development needs. All GPs were up to date with their yearly continuing professional development requirements and they had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in roles such as minor surgery and joint injections. Practice nurses were able to demonstrate that they were trained to fulfil defined specific roles. For example, on administration of vaccines and cervical cytology. Those with extended roles (for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers and health visitors to support patients and promote their welfare. The practice held multidisciplinary team meetings (monthly) to discuss the needs of complex patients, for example those with end of life care needs, vulnerable adults or children on the at risk register where concerns about their welfare had been identified.

Information sharing

The practice used electronic and face to face systems to communicate. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. Electronic systems were in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational in 2015. (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 an electronic document management system and electronic prescribing.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They provided us with examples which demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether 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 a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with documentation of explanation and consent obtained in the records.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, various cancers screening, health checks and travel advice.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical

Good

Are services effective?

(for example, treatment is effective)

health and wellbeing. For example, by offering opportunistic chlamydia screening, cervical screening, bowel cancer screening and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was around national average and CCG average. Seasonal flu immunisation rates for the over 65 group were above average for the CCG. There was a clear policy for following up non-attenders by the practice in conjunction with the health visitors and other relevant health care teams.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept up to date registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks. For example, the practice kept a register of all patients with dementia and records showed 100% had received a face to face review in the last 12 months. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered smoking cessation advice to these patients.

The practice's performance for cervical smear uptake was 96%, which was better than others nationally. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. Patients who did not attend screening programmes such as bowel cancer screening and mammography were also followed up.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area so as to avoid being overheard.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We looked at 25 CQC comment cards that patients had completed prior to the inspection and spoke with eight patients. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, felt they had confidence in the staff caring for them and that staff were attentive, caring and respectful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey 2014 found that 94% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. Ninety eight percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Eighty nine percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. These results were around average or above when compared nationally.

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

Care planning and involvement in decisions about care and treatment

Patients who we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their treatment, they received full explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results. Patients we spoke with told us that health issues were discussed with them and treatments were explained. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 they rated the practice well in these areas. For example, data from the National GP Patient Survey 2014 demonstrated 88% of patients said the GPs were good at involving them in decisions about their care and 93% felt the nurses were good or very good at involving them in decisions about their care. These results were around average and above when compared to the local CCG area and nationally.

Patient/carer support to cope emotionally with care and treatment

Patients, including members of the PPG, that we spoke with on the day of our inspection and the comment cards we received told us that staff were caring and compassionate and had helped patients emotionally through difficult times such as bereavement and diagnosis of long term health conditions and disabilities. Patients told us about help and support they had been given at the practice to set up carers support groups.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians were empathetic and compassionate. Results from the National GP Patient Survey told us that 87% of patients said the last GP they saw or spoke to was good at giving them enough time, 93% said the GP was good at listening to them and 95% said they were good at explaining tests and treatment.

The practice cared for patients with terminal illness and those coming towards the end of their life. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the

Good

Are services caring?

care plans and support needs of patients and their families. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Staff spoken with told us that bereaved relatives known to the practice were offered support. GPs would ring patients up to offer support. GPs and the practice nurse were able to refer patients on to counselling services.

Notices in the patient waiting room also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There were active carer support groups available to patients, some of these were organised by members of the practice patient participation group. There was a variety of written information available for patients and carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to improve and maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

We were told the practice engaged with the NHS England Area Team, Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered home visits and extended appointments for those with enhanced needs. This was to ensure patients had appointments to meet their needs for care and health reviews. Patients received their relevant annual health checks and had care plans in place.

The practice engaged with the enhanced service for unplanned admission to hospital which assesses and care for patients at high risk of unplanned hospital admission. Figures for April (2015) demonstrated that 96% of these at risk patients had an agreed care plan that had been reviewed.

Clinical staff undertook home visits and had specific disease management clinics weekly to review patients' health, care plans and medication. Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. The practice was proactive in early identification of patients with dementia. They screened patients aged over 75 and demonstrated since the introduction of the screening their diagnosis rate had increased greatly in the last 12 months. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had an active patient participation group (PPG). We spoke with five members of the group. They told us that the practice engaged with patients and gained their views formally through surveys, comment cards and meetings as well as informally. They told us the practice welcomed suggestions and ideas for service improvements from the PPG and acted upon suggestions made. For example the group suggested the use of televisions for music in the waiting areas to aid confidentiality. This was acted upon.

Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was disabled car parking available. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and a room available for breast feeding mothers.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services and sign language for deaf patients. They had tailored services and support around the populations needs and provided a good service to all patient population groups.

We noted that the practice routinely provided equality and diversity training for all staff.

Access to the service

The practice was open Monday, Tuesday, Thursday and Friday 8.00am until 6.30pm. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable, on the day appointments and home visits. Appointments could be made in person, online or by phone. Currently there were no routine extended hours any day of the week; however patients did not raise this as a concern when we spoke to them or reviewed comments made by them. The practice told us they were considering offering extended hours as their

Good

Are services responsive to people's needs?

(for example, to feedback?)

clinical staff complement increased this year. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition and these patients were always offered a same day or urgent appointment.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients. Patients told us they did not always get to see the GP of their choice. This was confirmed by the patient survey results which told us that only 42% of patients with a preferred GP usually got to see that GP. We were told, and patients confirmed, that they always got an appointment on the day if needed.

Patients we spoke with, comment cards and patient survey results told us patients were satisfied with the appointment system. The practice performed well in patient surveys with 72% satisfied with the practice's opening hours. However only 56% said they found it easy to through to the practice by phone and 68% described their experience of making an appointment as good. This was lower than average. However patients told us this had recently improved with the introduction of online booking of appointments and a new telephone system.

Overall satisfaction with the practice (at the last patient survey) was good; 89% of patients described their overall experience of the practice as good, which was around the national average.

Patients and survey results told us there was no concern regarding waiting time when they arrived at the practice for their appointment. Seventy eight percent of patients responding to the national patient survey said they usually waited 15 minutes or less – which was higher than the local average. We were told by patients and in the comments reviewed that they felt the GPs gave them time, listened to them and did not rush them. They felt therefore if they had to wait this was justified by the good service given to individuals.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance. However we noted the policy incorrectly referred to the Healthcare Commission and Health Authority which are no longer operational. It did not give information as to other bodies patients could raise concerns with such as NHS England and the Care Quality Commission. The practice manager, administrative manager and clinical staff managed complaints and they liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. The practice reviewed complaints six to twelve monthly to identify themes or trends. Lessons learned from individual complaints had been acted on.

We saw that information was available to help patients understand the complaints system in the practice leaflet and on the website. Patients we spoke with were not aware of the complaints procedure, however they told us what they would do if they needed to make a complaint and none of the patients we spoke with had ever had cause to complain. Reception staff demonstrated knowledge of dealing with complaints and logging verbal complaints to be passed on to the practice manager.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to offer traditional GP values, high quality care and a personal approach by a friendly team. Staff were able to articulate the vision and values of the practice. However there was not a formal mission statement available. Lead members of staff were able to articulate their forward strategy and succession planning was evident and discussed.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the office. Generally policies and procedures were dated, reviewed and appropriate. Some, for example, the complaints policy needed review to ensure that it met the requirements and national guidance. Staff confirmed they were aware of how to access them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding, prescribing, palliative care, learning disability and mental health. We spoke with staff in different roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above the national average. For 2013/14 the practice obtained 97.9%. We saw that QOF data was regularly monitored and discussed between the team and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Clinical audits were undertaken regularly by nursing and medical staff. We looked at a selection of these. Generally they were completed well; with review of actions and improvements evident. Other reviews of care undertaken included case care reviews to look at patients' clinical management to identify if things could have been done better. Referral reviews and data challenges checked whether appropriate pathways of care were delivered by the practice and secondary services.

The practice had arrangements in place for identifying and managing risks such as fire, security and general environmental health and safety risk assessments.

The practice held regular clinical and practice team meetings that were documented. We looked at a sample of minutes from last year and found that performance, quality and significant events and complaints had been discussed.

Leadership, openness and transparency

Staff felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued, their views about how to develop the service were listened to and acted upon and suggestions for improvements considered and acted upon. The leadership team of the practice was caring, enthusiastic and motivated about the service they provided and about caring for their staff.

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

We looked at complaints and found they were dealt with appropriately. The practice investigated and responded to them in a timely manner, and complaints were discussed with staff to ensure staff learned from the event.

The practice had a current active Patient Participation Group (PPG). We spoke to five members who told us they felt the practice was proactive in listening to patients' views and acting upon them. They had a good working relationship with the practice team and felt valued and able to contribute to service improvement and developments.

The practice had gathered feedback from patients through patient surveys, friends and family test comments and complaints. Information was promoted in reception to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. We saw

Are services well-led?

Good

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

the results of the latest tests which were very positive with the majority of patients recommending the practice to others. For example the results of the latest friends and family test that demonstrated in February 2015 93% of respondents and in March 2015 92% of respondents said they were extremely likely or likely to recommend the practice to others,

The practice gathered feedback from staff through formal and informal staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Regular informal discussions and meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff had annual appraisals to review performance and identify development needs for the coming year. These were up to date.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. The practice had training and development half days each month at which staff would undertake training or learning through electronic means, by discussions and attended CCG wide development sessions.

The practice had completed reviews of case management, referral data, significant events, complaints and other incidents. The results were disseminated via email, verbally and discussed at practice meetings and as necessary changes were made to the practice's procedures and staff training.