Cradley Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 inspected this service on 2 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.

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

The provider should:

- Review all policies and procedures so that the provider can be assured that medicines are managed effectively, according to best practice and within legal requirements

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. 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 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 at the practice to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely.

People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. A schedule of appraisals and the personal development plans for all staff had been planned. Staff had received training appropriate to their roles and further training needs had been identified and planned. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care.

Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect and ensured confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Summary of findings

Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy with patients as their main focus and priority. High standards of care were promoted by all practice staff with evidence of team working across all roles. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity, and regular governance meetings had taken place. The practice proactively sought feedback from staff and patients and this had been acted upon where improvements had been needed. Patients were very positive and spoke highly of the practice. Staff felt they were valued as members of a caring and responsible team.

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 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. They provided 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 and home visits.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Emergency processes were in place and referrals were made for patients in this group who had a sudden deterioration in their health. Longer appointments and home visits were available when patients needed them. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of the population group of the working-age people (including those recently retired and

Summary of findings

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 a full range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked as members of multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and other 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had in place advanced care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and other organisations. This included organisations such as the '2gether Trust' in Herefordshire and other community based services that provided support for patients of all ages with mental health needs. A community psychiatric nurse visited the practice once a week to see patients. This service was commissioned by the clinical commissioning group.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of the inspection. They included women and men of varying ages and population groups. Patients told us they were extremely satisfied with the service they received at the practice. They told us they could always get an appointment at a time that suited them, including same day appointments. They had confidence in the staff and said they were always treated with dignity and respect.

Two patients were mothers with young children. They told us they were always able to get appointments the same day. They said they were seen on time or shortly after their appointment time, which they appreciated. They told us they were treated with consideration by all staff and that the GPs were very supportive. They said they were given clear information about the matters which concerned them and were fully involved in discussions about treatment for themselves or their children.

Older patients told us they were always able to get appointments as required and that their named GP would visit them at home if they needed this. They described the care and support provided by the practice as exceptional and very caring.

Three patients of working age said they found it straightforward to access the practice by telephone and were able to get an appointment that was convenient for them. They told us the reception staff were always helpful and understanding.

We reviewed the 25 patient comments cards left for us in a sealed box prior to the inspection. We saw that all comments were extremely positive. Patients told us that all experiences at the practice including the dispensary had been excellent. They commented that staff were always friendly and helpful. They also told us they felt listened to and did not have to wait for appointments.

We looked at the national GP Patient Survey published in May 2014. The survey found that 93% of patients rated Cradley Surgery as good or very good; 98% of patients said they would recommend the practice to someone new to the area; 83% of the patients who responded reported that they had had a good experience in making appointments at the practice; 98% of patients indicated they were satisfied with phone access.

Areas for improvement

Action the service SHOULD take to improve

The provider should review all policies and procedures so that they can be assured that medicines are managed effectively, according to best practice and within legal requirements.

Cradley Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team also included a second 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 Cradley Surgery

Cradley Surgery is located in Cradley, near Malvern in Worcestershire and provides primary medical services to patients. The practice area is centered on Cradley village, and includes outlying villages and certain parts of Malvern. Cradley Surgery has a General Medical Services contract and is also a dispensing practice.

Cradley Surgery is an approved GP training practice. Fully qualified doctors (registrars) who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP.

The practice has one male and three female GPs, a male registrar, a practice manager, an assistant practice manager, two practice nurses, one healthcare assistant, dispensing, administrative and reception staff. There were 3492 patients registered with the practice at the time of the inspection. The practice is open from 8.30am to 11.30am and 4pm to 5.30pm Monday to Friday. Urgent appointments are available from 10.30am to 1pm daily. Home visits are available for patients who are too ill to attend the surgery. The practice has four early morning appointments available on Tuesdays and Wednesdays for those patients who find it difficult attending during normal surgery hours.

The practice treats patients of all ages and provides a range of medical services. Cradley Surgery has a higher percentage of its practice population in the 65 and over age group than the England average. The practice provides a number of clinics such as asthma, diabetes and healthy heart clinic. It offers child immunisations, minor surgery, and maternity and child health surveillance services. Practice nurses can be seen by appointment for blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. 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.

The practice works closely with another small local practice. This provides both practices with clinical support. They share staff and resources for the benefit of their patients. For example, the practice manager works part time at this practice and part time at the other practice. The practice manager is supported by a full time assistant practice manager at Cradley Surgery. Both managers have been in post since April 2014. Alongside other significant staff changes during that time they have worked to develop and improve operating systems and procedures within the practice.

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

Detailed findings

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 Care Quality Commission (CQC) at that time.

How we carried out this inspection

Before our inspection of Cradley Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Herefordshire Clinical Commissioning Group (CCG), the NHS England local area team and the Local Medical Committee (LMC) to consider any information they held about the practice. We spoke with the manager of residential home supported by 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 2 October 2014. During our inspection we spoke with a range of staff that included three GPs, the practice manager, the assistant practice manager, the nurse practitioner, two nurse consultants, a health care assistant and reception staff. We also looked at procedures and systems used by the practice.

We spoke with eight patients who visited the practice and observed how staff interacted with them. We reviewed 25 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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw that significant events had been discussed at practice meetings over the last year which demonstrated willingness by staff to report and record incidents.

We reviewed safety records and incident reports for the past year. This showed the practice had managed these consistently over time and could evidence a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, a member of staff told us about two recent incidents that had involved blood test results received by the practice. They confirmed that action had been taken by the practice and that this information had been shared with the staff team.

All staff we spoke with were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and business meetings to ensure everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that any action taken 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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They 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 were easily accessible.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to level three (advanced), 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 through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, a clinician told us about the procedure they had followed recently when they had concerns about children who had attended their clinic.

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 which ensured staff were alerted to any relevant issues when patients attended appointments. We found that GPs used the required codes on this electronic case management system to ensure risks were clearly flagged and reviewed.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consulting 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 only carried out by clinical staff.

Good

Are services safe?

Medicines Management

We saw that the practice had policies and procedures in place for the management of medicines dated June 2014. Staff we spoke with were aware of these policies and procedures and confirmed they were able to access these as required.

The dispensary manager told us they had been in post for approximately six months. They told us they had made many changes to the management of the dispensary during that time and had an action plan in place for on-going improvements and development of the dispensary.

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 for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. Nominated clinical staff were responsible for checking and replacing any out of date stock used for emergencies and during home visits. We found out of date medicine, needles and syringes in the home visit bag. Records showed that the home visit bag was last checked on 28 August 2014. The expiry date of the medicine was clearly recorded as having expired in April 2014, but the medicine had not been removed. The out of date medicines had been removed from the home visit bag by the practice during the inspection. Following the inspection the practice manager confirmed that a new home visit bag had been purchased that was easier to use and check the contents. They sent us a copy of the policy to confirm that it had been amended and that staff had been informed of the revised procedure.

Dispensary staff told us that emergency and home visit medicines were replaced immediately after use.

We saw that standard procedures were in place that set out how the use of controlled drugs was managed. We saw that controlled medicines were stored securely and robust procedures were in place for ordering and dispensing of these medicines. We saw that a clear audit trail was available for the disposal of out of date controlled medicines that belonged to the practice. The practice had a waste disposal contract in place for the safe disposal of medicines and controlled medicines returned by patients. We saw records were kept for all medicines disposed of by the practice.

We found that prescription pads were not stored securely to prevent unauthorised access by staff. We found six prescription pads in an unlocked cupboard. The practice manager confirmed that they had no system to record how the receipt and use of these prescription pads was monitored. Action was taken and information was sent to us following the inspection. This information confirmed that appropriate arrangements for prescription pads had been reviewed and that all prescription pads held at the practice were now stored securely. The practice sent us a copy of their revised policies for the handling and storage of prescription pads, which had been updated to reflect these new arrangements.

Dispensary staff showed us how safety alerts involving medicines were brought to their attention. We saw safety alerts were available within the dispensary and were signed by relevant staff to show they had been read and appropriate action taken.

We saw that emergency medicines were available in the treatment room where clinics were held. Records showed that these medicines were checked monthly. We saw records held of vaccines and immunisations received including batch numbers and expiry dates. We saw that these medicines were securely stored in a medicines fridge and that stock was rotated. Records showed that these medicines were stored within the temperatures recommended by the manufacturer. Staff spoken with were aware of these temperatures and what action to take if the temperatures fell outside this range.

Vaccines were administered by nurses 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 had received appropriate training to administer vaccines.

We found that records were not available for monitoring the temperatures of other medicines. Staff told us that room temperatures within the dispensary and treatment room were not monitored. Immediate action was taken by the practice and information that confirmed this was sent to us following the inspection. This showed that the storage temperature monitoring arrangements for medicines had

been reviewed and that all medicines held at the practice were now stored and monitored appropriately. The practice sent us a copy of their policy and procedure for the handling and storage of medicines, which had been updated to reflect these new arrangements.

The provider should review all policies and procedures so that they can be sure that medicines are managed effectively, according to best practice and within legal requirements.

We saw an incident log held in the dispensary where minor incidents involving medicines were recorded. Staff told us these incidents were discussed at their monthly dispensary staff meetings. Staff said the reason for discussion was to review whether these incidents could have been avoided and any actions identified. The dispensary manager told us action plans were put in place and reviewed to ensure that the same issues did not reoccur. Staff told us no major drug incidents had occurred at the practice. Dispensary staff told us they were aware that the dispensary manager planned to complete a medicine audit in the near future.

There was a protocol for repeat prescribing which was in line with national guidance. We saw this was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there although there were cleaning schedules in place and cleaning records were kept, these had been inconsistently completed. Patients we spoke with told us they 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 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 did not have a lead for infection control at the time of the inspection although this role was covered temporarily by clinical staff. The practice had recently recruited a practice nurse with plans for them to become responsible as infection control lead once they had started work at the practice. The practice manager told us that further training to enable them to provide advice on the practice infection control policy and staff training would be provided.

All staff received induction training about infection control specific to their role. We saw evidence that annual audits had been carried out and that any improvements identified for action were completed on time. Practice meeting minutes showed that the findings of the audits had been discussed.

The practice had policies and systems in place to protect staff and patients from the risks of health care associated infections. For example, we saw the policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Although a legionella risk assessment had yet to be completed we saw that plans were in place for this to be done and kept under regular review.

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. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

Equipment

Staff told us they had sufficient equipment to enable them to 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 records

that confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order and that measurements were accurate.

We found however that there were some gaps and lapses in the frequency of the electrical equipment checks recorded. We were assured by the practice manager that checks would be completed during November 2014. We saw that this action had been identified for completion by an external contractor by the practice in their work plan completed September 2014.

Staffing & Recruitment

Recruitment and selection processes were in place to ensure 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. However, the policy had not included information about criminal record checks and checks specific to clinical staff. The practice had identified the need to review their policy by December 2014 according to their improvement work plan dated September 2014.

We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions to reduce the risk of unsuitable people working with vulnerable adults and children. We saw however, that a DBS check from a previous employer dated 2012 was in place for a relief member of clinical staff. Following the inspection the practice manager confirmed that an application had been made for a new DBS check for this member of staff and that a risk assessment had been put in place until this had been completed.

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.

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 ensure patients were kept safe. The practice manager told us that staffing levels and skill mix were determined and based on historical needs. We were shown a staff rota for the practice dated August 2014; however there was no rota available for September 2014. We were told this was due to the unexpected absence of clinical staff. Management staff told us that GPs had increased their availability to cover clinics to ensure that these had continued to be available for their patients. Discussions with clinical staff confirmed this.

During busy periods management staff assisted the reception team and the GPs tried to make more appointments available for patients. Expected absences such as annual leave were managed through placing limitations on the number of staff in each area of the practice taking leave at one time. Staff told us they worked well as a team and supported each other in their roles. They considered this was made possible because they were such a small practice. For example, GPs would answer phones while they were doing admin tasks, the health care assistant would cover reception, and the dispensary team would also book patients in for appointments.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy in place. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We found that although not all the policies and procedures had been updated, the management staff were aware of this and had made arrangements to review and update these.

Identified risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team and discussions about action to be taken had recorded in the minutes.

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 did not attend.

Emergency processes were in place and referrals were made for patients with long term conditions who had a sudden deterioration in their health. We saw that care plans were in place that provided patients with relevant information about their condition with emergency contact details should they be needed. The care plans also provided relevant, up to date information about a patient's condition and their treatment to inform health professionals in an emergency. 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.

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 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.

We saw that emergency medicines were available in the treatment room where clinics were held.

Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked in the treatment room were in date and fit for use. We found during the inspection that out of date medicine had been contained in the home visit bag. Immediate action was taken by the practice to address this.

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 a heating company to contact in the event of failure of the heating system, and utility services such as electricity, gas and water suppliers. The practice managers confirmed that copies of this plan were held off site with designated management staff.

Good

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). GPs demonstrated that they followed local commissioner's protocols regarding clinical decisions such as changes in care pathways.

We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and any required actions were agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given the 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 and these were reviewed when appropriate in line with NICE guidelines.

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 requires GPs to demonstrate that they have 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 made sure that patients were referred on need and that age, sex and race was not taken into account in this decision-making process.

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). QOF is a national performance measurement tool used to assess performance. We saw there was a robust system in place to frequently review QOF data and recall patients when needed.

The practice had a system in place for completing clinical audit cycles. We saw examples of completed audits and audits that were on-going. For example, audits had been carried out on prescribing for medicine to treat high cholesterol and an antidepressant. We saw that patients' prescriptions had been reviewed as a result of these audits and where appropriate changes had been made. We saw that further audits of the changes had been made to assess and evaluate the effectiveness of the changes implemented, thereby completing the audit cycle.

We saw audit cycles that had been completed which were scheduled to be re audited early in 2015. For example, GPs described a more complex audit they had undertaken in response to NICE guidance. This audit had been done for patients who were prescribed medicine for abnormal heart rhythm. This audit had required the practice to work in conjunction with a local hospital to extract data. Action was taken as a result of the audit and where required reviews of patients' medicines had been completed. This audit identified the need for regular on-going re-audits with continued joint work with the hospital.

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 completed cervical smear audits and these were reviewed externally. Clinical staff told us audits were done and were discussed at meetings. They gave examples of infection control and fridge temperature 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 regularly checked that patients who received 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 went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

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. A good skill mix was noted amongst the GPs. GPs had additional interests in diabetes, asthma, heart disease prevention, 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 found that some staff had received annual appraisals. We saw that where appraisals had been carried out action plans had documented each person's identified learning needs. We noted from the practice improvement plan of September 2014 that priority had been given to setting staff appraisal dates and reviewing mandatory training for all staff.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to qualify as GPs were offered extended appointments and had access to a training lead GP for support throughout the day. Feedback given to us by a trainee was positive.

Practice nurses had defined duties they were expected to perform. They were able to demonstrate they were trained to fulfil these duties, including 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. Those with extended roles were trained in the diagnosis and management of patients with complex medical conditions such as diabetes and respiratory disease.

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

The practice held multidisciplinary team meetings regularly 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 relevant professionals such as health visitors and palliative care nurses. We saw minutes of meetings that confirmed this. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aimed to offer patients a choice of appointment at a time and place to suit them. The data produced by the Wye Valley Trust showed comparisons for Herefordshire and Cradley Surgery. The data showed the practice made good use of the Choose and Book system; usage showed as approximately 82% which was the third highest for the county. The GPs told us that they completed referrals to another service with the patient as part of their consultation. Referrals were completed either via electronic templates or audio file, and were usually processed on the same day.

The practice supported people who experienced mental health problems and had established links with Child and Adolescent Mental Health Services (CAMHS). CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. The practice also had a mental health nurse attached to the practice to provide support to patients.

Good

Are services effective?

(for example, treatment is effective)

Although the practice had a minimal number of patients with problems linked to substance misuse, GPs told us they had links to services in Hereford, such as drug and alcohol services.

We spoke with the staff from local care homes whose patients were cared for by the practice. They told us the practice supported patients through regular weekly visits to the homes. 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 or being trained on the system. The use of the record system was also discussed at clinical patient care meetings to ensure a consistent approach in the use of these records by clinical staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information. Information for patients about this was available on the practice website, with a form available to enable patients to opt-out from having a Summary Care Record if they chose.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and assessment of Gillick competency (which helps clinicians to identify children under 16 years of age who have the capacity to consent to medical examination and treatment), of children and young adults. Clinical staff told us that patients had a choice about whether they wished to have a procedure carried out or not. For example, a practice nurse told us how they would talk through the procedure when they were to take blood samples with the patient if they appeared anxious or uncertain. They told us they would discuss any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. An appointment was made for them to return to the practice to allow them more time to make their decision.

Staff told us they completed Mental Capacity Act training through an on-line course. Clinical staff we spoke with understood the key parts of the legislation and were able to describe to us how they implemented it in their practice.

Staff told us the patient always came first and was encouraged to be involved in the decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Staff we spoke with gave examples of how patients' best interests were taken into account if patients did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies.

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 showed care plans were in place and that reviews had been carried out.

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 nurse. 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 or to review the patients long term condition.

The practice had 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 at risk groups such as patients who were obese, those patients likely to be admitted to hospital and those patients receiving end of life care. These patient groups were offered further support in line with their needs.

Good

Are services effective?

(for example, treatment is effective)

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 75 or over and patients with long term conditions were offered a named GP.

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 to patients on how to manage their conditions. GPs told us there were plans to provide self-management information leaflets for patients diagnosed with asthma.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Although last year's performance for all immunisations was average for the CCG area, the practice had a clear policy and procedure in place for following up non-attenders. This was done by either the named practice nurse or the GPs.

We saw a copy of the newsletter produced by the practice for Sept/Oct 2014 which gave patients information about the flu vaccination programme, the criteria for eligibility, the possible side effects, and the dates the clinics were to be held at the surgery for 2014. The leaflet also discussed the process for patients to follow should they wish to have their ears syringed.

We saw included in the newsletter information about the number of appointments missed by patients. This was given as 66 for the month of August 2014. We discussed this with the practice managers and we were told there was no formal process in place to respond to patients who regularly failed to attend for appointments.

We saw that a range of health promotion leaflets was 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 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.

Cradley surgery operated a patient carer protocol to identify carers they could signpost to support agencies for help should they need it. The practice had carer support information available for patients in the waiting room which gave contact details for Worcestershire carers support group.

Good

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 patient survey and a survey of patients undertaken by the practice. 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 among the best in the CCG area for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. Information showed that 88% of practice respondents said they would recommend the practice and 83% reported an overall good experience of the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 25 completed cards and all but one was positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The one less positive comment indicated the patient was unhappy because they did not have their own named GP. We also spoke with eight patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff told us that Cradley Surgery was a practice that cared for their patients and that being a small community practice they had built relationships with their patients. Staff told us they greeted patients warmly, with a smile and remained respectful at all times.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff confirmed they ensured patient's dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Patients were made comfortable and 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 practice manager. The practice manager told us she would investigate these and any learning identified 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 managers of the care homes supported by the practice. They described to us the caring, professional, supportive attitude of everyone who worked at the practice from GPs, to nursing and reception staff. They told us they were happy with the support they received from the practice and they felt able to ask for support at any time for their residents.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey showed 91% of practice respondents said the GP and the nurse was good at involving them in decisions about their care. This

Good

Are services caring?

was above the average 85% compared to the Clinical Commissioning Group (CCG) area; 98% of patients responded that they would recommend the practice to new patients.

Staff told us that the population of the patients at the practice were mainly white, British people, with Eastern European seasonal land workers. Staff told us that support for people whose first language was not English tended to come from their own supporters, although an interpreter service was available if needed. Leaflets in the patients preferred language were printed from the internet to help them understand their conditions as required.

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.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with during the inspection and the comment cards we received 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.

Notices in the patient waiting room and on the practice website 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.

Staff told us that families who had suffered bereavement were called and visited by their GP. Staff told us that they were aware that families could be signposted to other services for support. GPs would assess the support needed and were able to make appropriate arrangements such as a referral to the primary care mental health worker.

End of life care and bereavement information was available to patients and their relatives/carers in the waiting rooms. 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. Managers at the care homes supported by the practice told us that GPs always gave support where it was needed, and this often included the family members of patients at the homes.

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 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. For example, a discussion had taken place about the lack of mobility of some of the patients registered with the practice. It had been agreed that staff would no longer park in the practice car park to ensure more parking spaces were made available closer to the building for patients with poor mobility.

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

Longer appointments were available for patients who needed them and for those with long term conditions. Patients were also given appointments with a named GP or nurse. Home visits were made to some 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.

Staff told us that changes had been made for patients who attended for regular blood test appointments. Patients were offered five minute appointments so that their visit could be as painless and as short as possible. The change had been made as a result of patient and staff feedback.

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.

Female GPs 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 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 had recognised the needs of different groups in the planning of its services such as carers and vulnerable people 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 various avenues of support available to them should they need it.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and 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 on leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8.30am to 11.30am and 4pm to 5.30pm Monday to Friday. Urgent appointments were available from 10.30am to 1pm daily. Home visits were available for patients who were too ill to attend Cradley Surgery.

All clinics were available by appointment and patients could book these by telephone, online or at the reception desk at the practice. The practice offered four early morning additional appointments on Tuesdays and Wednesdays. These appointments were particularly useful to patients with work commitments. Working age patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

were able to access appointments through the online booking system. We spoke with two patients from this population group during the inspection who confirmed this system was easy to use.

Patients were generally satisfied with the appointments system. They confirmed 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.

The practice was accessible to patients. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Information leaflets for health promotion were available for patients to take away with them should they wish to do so.

The practice had a population of mostly English speaking patients though it could cater for other languages through translation services.

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 that had been taken to resolve each complaint. We looked at records of complaints and found these had been handled satisfactorily.

Accessible information was provided to help patients understand the complaints system on the practice's website, posters displayed in the waiting room and in the reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff told us they were aware of what action they should 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. A member of staff told us about a current patient concern that had been raised with them in regard to the music on the telephone being too loud when they were waiting to speak with staff. We were told this had been shared with the management team.

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

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 via the desktop on any computer within the practice. We looked at nine of these policies and procedures. Some of the nine policies and procedures we looked at had not been reviewed annually, but the practice manager told us that plans were in place to review these and ensure they were kept up to date. We saw the practice's work plan completed in September 2014 that confirmed this.

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% QOF points compared with the national average of 96%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits which included audits for new diuretic drugs (to prevent water retention), antibiotic prescribing, and an audit of heart failure. Following the audit the GPs carried out reviews for patients who were prescribed these medicines 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.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example, one of the partners was the lead for safeguarding and the Caldicott Guardian. Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff 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 the owner of the practice. Staff described the owner of the practice as wonderful, open and strong.

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.

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. We saw from minutes that team meetings were held regularly, at least bi-monthly or sooner if needed. Staff told us that there was an open culture within the practice and they had the opportunity and felt comfortable to raise any issues at team meetings.

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 August 2013 and from complaints received. Staff told us the practice shared the results with the whole team for discussion at a staff meeting. This gave staff the opportunity to give

Are services well-led?

Good

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

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.

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.

Staff told us the practice had recently acted following feedback from patients regarding the loudness of the music on the telephone. Another example given was when the dispensary had been short of staff and patients became unhappy with the service. A notice was made available to patients to advise them of the reasons why they were experiencing these problems and we were told by staff that this had satisfied patients.

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, clinical 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.

We saw how the practice responded to areas that needed to be improved. For example, we saw from meeting minutes that the practice had identified the need to review patients' admissions to hospital to determine the reasons for this. Where admissions had been considered avoidable the practice planned to review care plans three monthly to try to reduce further admissions.

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 on 5 June 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 is shared with staff at practice meetings. For example, a coroner's letter regarding an incident that involved a patient had recently been discussed.

The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current registrar. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team.