Dr Heath Prescot Medical Centre

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr. Heath, Prescot Medical Centre. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 10 February 2015 at the practice location in Prescot, Merseyside. We spoke with patients, relatives, staff and the practice management team.

The practice was rated overall as good. They provided effective, responsive care that was well led and addressed the needs of the population it served. The service was safe, caring and compassionate.

Our key findings were as follows:

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt were disseminated to staff. Infection risks and medicines were managed safely. However, improvements were needed to ensure staff were safely recruited and required information in respect of staff was held.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Patients experienced outcomes that were in line with or above the national average. The practice used innovative and proactive methods to improve patient outcomes. For example comprehensive care plans for vulnerable and older patients to reduce unplanned admissions and development of care plans and pathways for other population groups.
- Patients spoke highly of the practice. They said they were treated with compassion, 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.

Summary of findings

- The practice provided good care to its population that was responsive to their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- The practice monitored, evaluated and improved services. Staff enjoyed working for the practice and felt well supported and valued. There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly, the provider must:

- Take action to 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.

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In addition the provider should:

- Implement a system for identifying and managing local risks associated with the practice. For example general environmental and health and safety risk assessments.
- Ensure the recruitment policy was in line with current guidance and regulations and contains sufficient information to ensure a suitable process was in place for safe recruitment and induction of staff. Ensure that newly recruited staff are fully inducted and the induction is documented.

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?

Requires improvement

The practice is rated as requiring improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding lead members of staff. Medicines and infection control risks were managed safely.There were enough staff to keep patients safe. However improvements were needed to ensure that staff were recruited safely and recruitment arrangements included all necessary employment checks for all staff.

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 consistently high scores for QOF over the last few years (last year they obtained 100%). 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. Patients were involved in the development of their care and treatment plans. Staff had received training appropriate to their roles and there was evidence of appraisals and personal development plans 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 very complimentary and positive about the service and the care and treatment they received. Data showed that patients rated the practice higher than others for several aspects of care. They said they were treated with 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 saw that staff treated patients with kindness and respect, and maintained confidentiality.

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.

Patients said they found it easy to make an appointment with a named GP and that there was 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. 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 strategy for care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received regular performance reviews and attended staff meetings and learning and development events.

Information governance was managed safely with an information management risk assessment toolkit in place that was monitored. Improvements were needed to ensure a suitable system was in place for identifying, monitoring and managing general and environmental risks.

The practice was limited in developing services and service improvements due to the lack of space available to the practice in the premises.

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 the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. It offered 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 and 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 around the national average number of patients with long standing health conditions (54% 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 maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease 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 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.

Nursing staff and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments (for example 20 minute appointments for diabetic and 30 minute appointments for asthma and chronic obstructive pulmonary disease (COPD) reviews) and home visits

were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, the practice maintained a register of children on the child protection register and looked after children. Immunisation rates were above average for all standard childhood immunisations. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. For example there were weekly community midwife 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 if necessary. Adolescents (age 14 and over) that were on the learning disability register received annual health checks and care planning for transition to adult services.

Working age people (including those recently retired and students)

Good

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

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

Summary of findings

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 people with a learning disability. The practice had a well-developed care plan programme for the most vulnerable 2% of patients and these had a named doctor.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety five percent of people experiencing poor mental health had an agreed documented care plan and 85% 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 discussions for patients with dementia.

The practice worked closely with the Mental Health and Wellbeing Service in Knowsley led by the local NHS Mental health Trust. The service lead reported that the practice had worked well to develop accurate registers to inform the service and to deliver full assessments of patients' needs. The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND and SANE. Patients with a mental health crisis were accommodated, where possible, with same day appointments with a preferred clinician, outside of normal working hours if necessary.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection (including two members of the Patient Participation Group). We received 32 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 those with children.

All patients were positive about the practice, the staff and the service they received. They told us staff were helpful, caring, and compassionate and that they were always treated well 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 99% 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, 96% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety nine percent said they last GP they spoke to or saw was good at listening to them, whilst 93% 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 received no concerns regarding the appointment system on the day of inspection from patients we spoke with and the comments cards reviewed. Ninety one percent of patients responding to the National GP Patient Survey said it was easy to get through to the surgery by phone. Eighty one percent described their experience of making an appointment as good, with 97% saying the last appointment they got was convenient. Seventy three percent of respondents with a preferred GP got to see or speak to that GP. This was confirmed by patients we spoke with and 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 MUST take to improve

- Take action to 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.

Action the service SHOULD take to improve

- Implement a system for identifying and managing local risks associated with the practice. For example general environmental and health and safety risk assessments.
- Ensure the recruitment policy was in line with current guidance and regulations and contains sufficient information to ensure a suitable process was in place for safe recruitment and induction of staff. Ensure that newly recruited staff are fully inducted and the induction is documented.

Dr Heath Prescot Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP and a specialist advisor who was a Practice Manager.

Background to Dr Heath Prescot Medical Centre

Dr Heath, Prescot Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 5300 patients living in the Prescot area of Merseyside. The practice has four GPs (two male and two female), a practice manager, nurse clinician, practice nurse, administration and reception staff. The practice is also a GP training practice, offering support and experience to trainee doctors. Dr Heath, Prescot Medical Centre holds a Personal Medical Services (PMS) contract with NHS England. The practice achieved practice accreditation from the Royal College of GPs (RCGP) in November 2013. The RCGP Practice Accreditation is a voluntary quality improvement program that supports the organisational development of practice teams across England. The aim of the initiative is to ensure that General Practices provide high quality care to patients by pursuing rigorous quality improvements.

The practice is open Monday to Friday from 8.00am to 6.30pm with an extended surgery on Tuesday until 8.00pm. They are closed one half day per month for staff training and development. Patients can book appointments in person 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 Knowsley Clinical Commissioning Group (CCG). The practice is situated in an area with high deprivation. The practice population is made up of a higher than national average working age population and a lower than national average of patients aged under 40 years. Sixty nine percent of the patient population has a long standing health condition, whilst 56% have health related problems in daily life. There is a lower than national average number of unemployed.

The practice does not deliver out-of-hours services. These are delivered by St Helen's Rota who provides a service locally in Prescot.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band 6 representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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
- 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, GP partners, a GP registrar, 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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents 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. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice manager, GPs and any other relevant or involved staff investigated and reported the significant events. Documented evidence confirmed that incidents were appropriately reported. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. 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.

The minutes of practice meetings we reviewed showed that complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the previous 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice told us they did not carry out an overview of significant events every six to 12 months in order to identify themes or trends; however they were considering implementing a system to do this.

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. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team when relevant. GPs told us significant events were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice. We saw evidence of action taken as a result of analysis of significant events, for example, a safeguarding audit identified a training need for reception staff. This was reported as a significant event and training delivered.

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). They also told us relevant alerts were discussed at team meetings 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 up to date safeguarding child and adults, policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were easily available to staff on their computers and in hard copy. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in clinical and administrative areas.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received

relevant role specific training on 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. Staff were made aware through an alert system on the computer and electronic records of vulnerable people and their immediate families. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for guidance and advice were accessible.

The practice had a dedicated GP as lead in safeguarding. 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 completed all requested reports for child protection and serious case review meetings. All staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern. 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 them 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). We were told that only clinical staff acted as a chaperone; however chaperone training was planned for some reception/administrative staff who were able to undertake these duties and were suitably checked. 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 other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. 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. All medicines that we checked were found to be in date.

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 of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice had been identified as being above average. Audits had been undertaken and improvements noted were evident.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Medicines for use in medical emergencies were kept securely in the treatment rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked for function regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis. There was a system in place for monitoring and checking of medicines carried in GP bags. This was done by the practice nurse.

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 and regular meetings were held with them.

Cleanliness and infection control

We observed the premises generally to be clean and tidy, However we discussed with the practice that the patients and public toilet on the ground floor had a poorly functioning tap and the walls in some areas of the building

required maintenance and redecoration. The practice immediately took action in reporting the defects to the premises management who were responsible for maintenance of the building.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were processes in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities, couches were washable and clean and curtains were labelled with the date they were changed and renewed. This was six months ago. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves were available in the treatment/consulting rooms.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and clinical 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. Appropriate level of training and updates was evident for different roles (clinical and non-clinical). 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 2014. We saw the outcome report with actions implemented. The practice re audited every three months to ensure actions had been implemented and improvements seen. Improvements had been made to the environment as a result. Cleaning was carried out under contract and the cleaning standards and schedule was 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. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We saw records that confirmed the practice had regular checks carried out for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

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 equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). These were maintained and checked regularly.

Staffing and recruitment

We looked at six staff files including clinical and non clinical staff. We found that not all the required information relating to workers was available. The two most recently employed staff had evidence of a Disclosure and Barring Service (DBS) check having been undertaken (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). We did not see any evidence in the files of DBS or formerly Criminal Records Bureau (CRB) checks for other staff including clinical staff. The practice told us they had had such checks done at employment some years ago, however these were not recorded. We found evidence of one reference obtained for the two most recently employed staff but for all other staff there was no evidence of qualifications, photographic identification, medical references or job descriptions.

There was no evidence held in files of clinical staff's professional registration with the General Medical Council

Requires improvement

Are services safe?

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

There was an up to date recruitment policy in place. However this was not in line with current guidance and regulations and did not contain sufficient information to ensure a suitable process was in place for safe recruitment of staff.

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 chaperoning.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see however there was not an identified health and safety representative for the practice nor did we see evidence of risk assessments in place for general environmental, Control of Substances Hazardous to Health (COSHH), for example certain chemicals, staffing or equipment risks.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were not stored on site and had been archived.

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. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Staff we spoke with were aware of the business continuity plan and could describe what to do in the event of a disaster or serious event occurring for example in the event of an IT failure.

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment and medicines available that were checked and maintained, including access to oxygen and an automated external defibrillator.

The building was owned by NHS Estates who managed the premises. They had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that fire fighting equipment and fire safety equipment (such as fire alarm) were routinely checked and maintained under contract.

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 our discussions 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. NICE guidance was stored on the shared drive in the computer system so that staff had easy access to them. 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.

GPs and practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding, minor surgical procedures (joint injections) and various chronic diseases. 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.

Older patients and those with long term conditions and mental health needs including dementia were well cared for by the practice. All vulnerable older patients and patients at risk of unplanned admission to hospital had comprehensive care plans in place which were routinely reviewed with the extended multi-disciplinary team. Care plans were developed in conjunction with the patient; they were given a copy of the care plan and were encouraged to contribute details and information to it. Care plans and care plan discussions were being implemented for patients with dementia and for adolescents with mental and physical health problems.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions reflected the national standards for referral rates. All GPs we spoke with used national standards for referral, for example in suspected cancers. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP. In the absence of the named GP for the patient the duty doctor would assess and action any such information.

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

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment including written consent for minor surgical procedures. One of the GPs undertook joint injections and they did this in line with their registration and NICE guidance. The GP was appropriately trained to carry out this procedure and they ensured their skill and knowledge was kept up to date.

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 consistently high scores for QOF over the last few years (last year they obtained 100%) which demonstrated they provided good effective care to patients. QOF information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was 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, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Child immunisations rates were above the national average.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for

Good

Are services effective?

(for example, treatment is effective)

patients. The practice kept up to date disease registers for patients who were vulnerable and 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 annual health reviews.

The practice implemented the Gold Standards Framework for end of life care. One of the GPs took the lead for this group of patients supported by the practice nurse and administration staff. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings. 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.

The practice had a system in place for completing clinical audit cycles and maintained an annual audit program. Examples of clinical audits included antibiotic prescribing, audit of patients with impaired glucose regulation and their care/treatment, audit of patients prescribed insulin and use of the insulin passport, and safeguarding toolkit audit. We looked at some of these audits that the practice had undertaken. These were fully completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We were given examples of where audits had improved patient outcomes and ensured the practice worked within NICE guidelines, for example in patients with impaired glucose regulation and their care and treatment.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision and locality performance indicators. Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they received feedback through training days and at meetings.

Effective staffing

There was an induction check list in place which identified the essential knowledge and skills needed for new employees. We spoke to a new member of staff who confirmed that they had received an induction however we were told this was not documented. There were no induction records evident in the sample of staff records looked at.

An appraisal policy was in place. The lead GP undertook all appraisals for all staff. We saw that all staff had had a recent appraisal and evidence of annual appraisals was held in their files. We saw the format used that included developing an action plan to address any training or learning needs identified. We spoke to staff who told us the practice was supportive of their learning and development needs. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We spoke with a trainee GP who felt supported by the practice in their learning and development.

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 manager kept a record of training carried out by all staff. We noted that the system was not easy to follow and did not enable training needs to be identified easily to ensure good oversight and management of training and development. The practice manager told us that they would develop a system to enable them to maintain more detailed information about all training undertaken that would help them to plan for future training needs.

The GPs took the lead in clinical areas such as patients with long term conditions, patients with mental health illness and the elderly. The GPs were supported by the practice nurses in these roles such as leads for diabetes and heart disease. 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 these roles.

Working with colleagues and other services

The practice worked well with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. Information received from other agencies, for example the accident and emergency department or

Good

Are services effective?

(for example, treatment is effective)

hospital outpatient departments were 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. Clinical staff met with and attended multi-disciplinary team meetings to discuss health care needs of children and vulnerable adults where concerns about their welfare had been identified. Gold Standards Framework meetings were held and liaison occurred with district and palliative care nurses to review the needs of patients and their families on the palliative care register.

Information sharing

The practice used electronic systems to communicate with other providers. 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. We saw a variety of documented meetings between the practice and these staff which confirmed good working relationships between them and good review and joint decision making in patient care.

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.

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. They provided us with examples of 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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice had policies and procedures to support staff around consent, including guidance on "do not attempt resuscitation".

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and joint injections 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, obesity management 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.

The practice also 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 above average nationally and for the CCG. Seasonal flu immunisation rates for the over 65 group were also above average for the CCG.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease 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.

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 32 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring and helpful. 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 six 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. Ninety six percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good.

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 all 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 own 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.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey 2014 demonstrated 86% of patients said the GPs were good at involving them in decisions about their care and 90% felt the nurses were good or very good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

Patient/carer support to cope emotionally with care and treatment

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 91% of patients said the last GP they saw or spoke to was good at giving them enough time, 99% said the GP was good at listening to them and 93% said they were good at explaining tests and treatment.

The practice implemented the Gold Standards Framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings minutes. 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 following bereavement. GPs and the practice nurse were able to refer patients on to counselling services. The practice signposted carers to support led by community services.

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.

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 that were reviewed regularly.

The practice cared for a number of elderly adult patients who lived in a local care or nursing homes. Clinical staff undertook visits to review care plans, any new patients and medications. Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. 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 two members of the group and looked at their agendas and meeting minutes. Practice staff attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon. The PPG contributed to the practice patient survey that was undertaken annually and reviewed the questions asked to ensure they were relevant and topical. The PPG also reviewed the results and worked with the practice to improve services where they could.

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 a large waiting area for patients attending an appointment and car parking was available nearby. There were disabled toilet facilities and an induction hearing loop.

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. They had tailored services and support around the populations needs and provided a good service to all patient population groups.

The practice did not routinely provide equality and diversity training for all staff.

Access to the service

The practice was open Monday to Friday 8.00am until 6.30pm with extended opening hours once a week until 8.00pm. They were closed one half day per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advise 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 and urgent (on the day) appointments and home visits. Appointments could be made in person, by phone or online. 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 we spoke with, comment cards and patient survey results told us patients were satisfied with the appointment system. They told us there was usually no difficulty getting through to the practice on the telephone or getting an appointment. The practice performed well in patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

surveys for access to the appointments system with 82% satisfied with the practice's opening hours, 91% saying they found it easy to through to the practice by phone and 81% described their experience of making an appointment as good. Overall satisfaction with the practice (at the last patient survey) was good; 96% of patients described their overall experience of the practice as good, which was higher than the national average.

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. The practice manager and partner GP managed the 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. A summary and overview log was not in place which would have enabled analysis of the complaints into subjects and themes. Complaints were not reviewed overall on an annual or more frequent basis. Complaints were discussed individually and regularly at meetings to disseminate learning and improvements in practice.

Patients we spoke with were aware of the complaints procedure. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. We noted this did not detail information regarding other contacts to which a patient could raise concerns such as the local NHS England team and the Care Quality Commission. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone.

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 improve patient outcomes in particular, through the development of the care planning strategy, for patients who may be elderly, vulnerable, young adults or have dementia. We did not find that the vision or a mission statement was displayed for staff and patients to see.

Staff were able to articulate the vision and values of the practice. The GP partners worked together to develop a clinical care planning strategy. It was identified that the building the practice operated from did not afford them sufficient space for which to develop initiatives and service improvements. They were limitations to service enhancement and developments unless they could gain more clinical and administrative rooms.

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 offices. Generally policies and procedures were dated and reviewed appropriately and were up to date. Some for example the recruitment policy needed review to ensure that it met the requirements relating to safe recruitment of staff. Staff confirmed they had read them and 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; GP leads for safeguarding, 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. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

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 100%. We saw that QOF data was regularly monitored and discussed at team meetings and action plans were produced to maintain or improve outcomes.

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.

The premises management had arrangements in place for identifying and managing risks such as fire and security risk assessments. The practice did not have a system in place for identifying and managing local risks associated with the practice. For example they did not have general environmental or health and safety risk assessments. On discussion with the practice manager they told us they would implement a risk assessment and system to mitigate such risks.

The practice held regular practice meetings that were documented. We looked at sample minutes from these and found that performance, quality and significant events and complaints had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example being open, bullying and harassment, recruitment and selection policies which were in place to support staff. Some of the human resources procedures needed review to ensure that they met requirements for safely recruiting staff. Recruitment and induction procedures needed to reflect policy and ensure that when staff are recruited and inducted full information in respect of these is documented.

There was a well-established clearly identified leadership structure. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. The lead GP had undertaken a course in clinical leadership in order to gain appropriate skills. There was a practice manager in post whose responsibilities were not clearly defined. They did not have

Are services well-led?

Good

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

a job description in place and on discussion it emerged that they were also undertaking administrative roles that limited them to fully develop in the managerial role. The practice had acknowledge that the practice manager required more time in which to fulfil their role and this was being addressed by advertising for further administrative staff to free up management time.

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 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 at staff meetings to ensure staff learned from the event.

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate. 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.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events. The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Regular monthly 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

We saw that all staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and a good two way process. The practice had an induction programme however this was not fully documented. Staff undertook training relevant to their role.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice had training and development half days each month at which staff would undertake training or learning though electronic means and attended CCG wide development session.

The practice was a GP training practice and we found that trainee doctors were well supported by the GPs and other staff.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **People who use services and others were not protected against the risks associated with unsuitable staff because the provider did not have an effective procedure in place to assess the suitability of staff for their role. Not all the required information relating to workers was obtained and held by the practice.**