Waterloo 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Waterloo Medical Practice on 14th July 2015. Overall the practice is rated as outstanding

Specifically, we found the practice to be outstanding for providing, effective, responsive and well led services. We have rated the practice as good for providing safe and caring services to patients.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients registered with the practice.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients 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.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients
- The practice had a clear vision that had improvement of service quality and safety as its top priority. High standards were promoted and there was good evidence of team working

We saw several areas of outstanding practice including:

Summary of findings

- The practice took a proactive role in working collaboratively under a neighbourhood scheme to clinically co-ordinate hospital and community care for patients deemed to be at risk within the practice.
- The practice offered a referral to a family nurse practitioner to all teenage pregnancy mothers to support and coach them through their pregnancy and first year of their child's life.
- The practice had achieved the Navajo Kite Mark as a Lesbian, Gay, Bisexual and Transgender friendly practice.
- The practice had a comprehensive sexual health programme that they could demonstrate reached all areas of the local population even those not registered with the practice.
- Smoking cessation clinics run by the practice pharmacist demonstrated a higher than Clinical Commissioning Group (CCG) average success rate over a four week period. (Practice 49% success against a CCG average of 36%)
- The GPs offered medical cover for three intermediate care beds in a local nursing home, this assisted patients awaiting intermediate care beds to be moved out of local NHS hospitals and free up beds.
- The practice phone line were open 8am - to 8pm Monday to Fridays except Thursday when they close at 6.30pm. Appointments are offered between 8.am and 8pm every day except Friday when they offered appointments until 6.30pm. They also offered Saturday morning clinics for long term conditions management.

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

The provider should;

- Ensure the practice leaflet on the website is updated to reflect changes in staff.

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 systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. However some significant events were not fully recorded, dated, investigated and shared with all staff as appropriate. All staff had received safeguarding training and staff we spoke with were aware of the safeguarding vulnerable adults and children policies in place. There were systems in place to ensure medication including vaccines, were stored correctly and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use. The practice had emergency equipment and medication available including oxygen and an automated electronic defibrillator. Daily checks on this equipment was formally recorded.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at our inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes.

Are services caring?

Good 

The practice is rated as good for providing caring services. Patients we spoke with and those who completed the CQC comment cards were very complimentary about the service. They said all the staff they came into contact with were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure sustainable improvements to

Summary of findings

services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information on how to make a complaint was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff took an active part in leadership within the practice. The practice had a number of policies and procedures to manage all activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which was acted upon. The patient participation group (PPG) was virtual and the practice sometimes struggled with engagement of the group, as a result of this the practice were trying to arrange face to face meetings for the group. Staff had received inductions, regular performance reviews and attended staff meetings and events. The GPs at the practice were proactive in offering support and training to nursing and medical staff and were regularly approached by the local Deanery to facilitate extensions to training for trainee GPs. The practice had a shared philosophy of what they wanted for their patients and everyone worked together to achieve this.

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.

The practice kept a register of those patients 75years and older. The practice offered a named GP for these patients. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. Staff were knowledgeable about what constituted a safeguarding concern. One GP took the lead for safeguarding supported by all other GPs and the nursing team who had all completed training to level 3. Risk management and information relating to safety was monitored, reviewed and addressed.

People with long term conditions

Outstanding

The practice is rated as outstanding for providing effective services. Care and treatment was delivered in line with current published best practice. Staff meetings and audits were used to assess how well the service was delivered.

The practice took a proactive approach to long term conditions (LTCs), practice statistics demonstrated a high prevalence of chronic diseases (68.1%) which is higher than both Clinical Commissioning Group (CCG) and national averages. (65.3% CCG, 54% nationally) The practice had large numbers of patients who suffered with chronic disease with 88.7% (per 1000 of population) of the practice population claiming some form of disability allowance.

The practice had a higher than national prevalence of HIV patients registered with the practice. In Blackpool 360 from every 100,000 of population being HIV positive compared to national averages of 145 per 100,000 of 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. 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 diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient conditions effectively and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

Summary of findings

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people.

Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances. Staff were proactive in reporting any concerns to the GPs and nursing team and were able to articulate examples of this.

Immunisation clinics for babies and young children were available on a weekly basis. Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies. Children needing urgent appointments were seen as soon as possible at the surgery. Children and young people were treated in an age appropriate way and recognised as individuals.

The population of under 18 year olds (0-18 years) accounted for 32.6% of the practice patient population which is higher than both the Clinical Commissioning Group (CCG) and the national averages for this age group (29.2% and 31.9%) . 21.8% of these were aged between 14-18 years of age compared with CCG averages at 13.7% and nationally 14.7%.The practice offered services to support pregnant teenage girls including a family nurse practitioner. The practitioner worked one day a week with the person as life coach and support for the young person from the 16th week of her pregnancy until the baby was two years old. Statistics demonstrated the practice was now below the national average for teenage pregnancies this has been attributed to an enhanced sexual health programme instigated by the practice. However Blackpool is still rated as the seventh worst nationally and second worst in the North West for teenage pregnancy. The practice offered a comprehensive sexual health programme for all people within the area not just those registered with them.

Working age people (including those recently retired and students)

Outstanding

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

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice offered late appointments for working patients in the evening from Monday to Thursday and offered a Saturday clinic for long term conditions.

People whose circumstances may make them vulnerable

Outstanding 

The practice is rated outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. Patients with learning disabilities were offered annual health checks and longer appointments were available if required. The practice effectively supported carers who were sometimes vulnerable themselves alongside the person they were caring for. The practice supported patients living in the local area with alcohol and drug dependency problems. The practice actively sought to include these vulnerable patients in the ongoing management of their care by a variety of means including offering appointments at short notice.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise the 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. We were shown evidence to demonstrate where the vigilance of administration staff had instigated activity to ensure the protection of vulnerable patients within the practice on a number of occasions.

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). Patients within this group received a timely recall for their annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service available. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia. The practice

Summary of findings

shared care of their dementia patients with a local agency to ensure appropriate support was available. Clinical Commissioning Group (CCG) statistics demonstrated the practice were the fourth highest of 22 practices at diagnosing their patients with dementia. (76.1% diagnosed with highest CCG practice being at 89% and lowest at 31.6%)

Statistics provided by the practice demonstrated the practice area had the second highest suicide rate in males nationally and was the fourth highest across both genders nationally. The practice explained these figures included people from outside the area who came to the coast to commit suicide.

Summary of findings

What people who use the service say

During our inspection, we spoke to 6 patients they all gave us positive feedback about the staff and the doctors at the practice.

We received 12 completed CQC comment cards; all praised the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

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 January 2015 demonstrated they performed well with 93.6% of respondents who described their overall experience of this surgery as good and 86.1% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG 82.6% National 81.5%). 48.5% of respondents with a preferred GP said they usually got to see or speak to that GP (60.3% CCG & 60.5% National). These percentages were in line with the average results for the local Clinical Commissioning Group (CCG) and national data available.

The practice had analysed the results of the returned Friends and Family Test questionnaires for June 2015. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience). The comments from these questionnaires were analysed and the outcome reviewed and shared at team meetings. Actions to improve the service were identified. The findings included 90.48% of respondents were likely or very likely to recommend the practice to friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the practice leaflet on the website is updated to reflect changes in staff.

Outstanding practice

- The practice took a proactive role in working collaboratively under a neighbourhood scheme to clinically co-ordinate hospital and community care for patients deemed to be at risk within the practice.
- The practice regularly supported GP trainees who were in need of extension to their training.
- The practice offered places on their training programmes to other practices in the local area.
- The practice offered a referral to a family nurse practitioner to all teenage pregnancy mothers to support and coach them through their pregnancy and first year of their child's life.
- The practice had achieved the Navajo Kite Mark as a Lesbian, Gay, Bisexual and Transgender friendly practice.
- The practice had a comprehensive sexual health programme that they could demonstrate reached all areas of the local population even those not registered with the practice.
- Smoking cessation clinics run by the practice pharmacist demonstrated a higher than Clinical Commissioning Group (CCG) average success rate over a four week period. (practice 49% success against a CCG average of 36%)
- Care planning for unplanned admission to hospital was able to be updated automatically if the patient attended A&E or their circumstances changed, this was then shared in 'real' time with other services such as Out of Hours.

Summary of findings

- The GPs offered medical cover for three intermediate care beds in a local nursing home, this assisted patients awaiting intermediate care beds to be moved out of local NHS hospitals and free up beds.
- The practice phone line were open 8am - to 8pm Monday to Fridays except Friday when they close at 6.30pm. Appointments are offered between 8.am and 8pm everyday except Friday when they offered appointments until 6.30pm. They also offered Saturday morning clinics for long term conditions management.

Waterloo Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP and a practice nurse specialist advisor

Background to Waterloo Medical Centre

Waterloo Medical Practice is situated in Blackpool Lancashire. It is part of the NHS Blackpool Clinical Commissioning Group (CCG.) Services are provided under a personal medical service (PMS) contract with NHS England. There are 11,114 registered patients. The practice is situated on a busy main road with limited parking on site for patients but street parking is available. The practice is situated in the second most densely populated area outside of London and serves the fifth most deprived ward in the country. Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice area has the second highest suicide rate amongst males in the country and is the fourth highest across both genders nationally. Statistics show the area's teenage pregnancy levels are the seventh worst nationally and the second worst in the North West. Mortality from cardiovascular disease is in the worst 10% of the North West. The practice works closely with a local incentive called Springboard, which is a multi-agency task force working to manage approximately 200 people in the local area who are high consumers of probation/ police/ criminal justice/ health/ social services and benefits. The practice offers support as required to people registered with this scheme.

The practice population includes a lower number (24.3%) of people over the age of 65, and a higher number (32.6%) of people under the age of 18, in comparison with the national average of 26.6% and 30.2% respectively. The practice also has a higher percentage of patients who have caring responsibilities (27%) than both the national England average (18.4%) and the CCG average (20.9%).

The practice telephone lines opens from 8.00 am to 8.00pm Monday to Fridays except Friday when they close at 6.30pm. Saturday morning appointments are available. Appointments are offered between 8.am and 8pm every day except Friday when they are offered until 6.30pm, they also offer Saturday morning surgeries. They hold seasonal Flu vaccination clinics at certain times of the year. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's Urgent Care Centre.

The practice has 5 GP partners, 1 Salaried GP, Locum GPs, 5 nurses, 2 health care assistants, a pharmacist and an administrations and reception team. The practice is a training practice for doctors who wish to gain experience as GPs, with two doctors currently in training. The practice had been recognised as a practice that is successful in supporting GP trainees who have required an extension of their training programme.

On-line services include appointment booking and ordering repeat prescriptions and access to medical records.

The practice successfully achieved the Narajo kite mark highlighting it as Lesbian, Gay, Transgender and Trans sexually friendly to the local population.

Detailed findings

One female GP at the practice has in recent years been awarded Doctor of the year in a Health Heroes in the Community scheme for their willingness to go the extra mile for patients. One GP at the practice is a Section 12 certified GP who can assist patients requiring sectioning under the Mental Health Act 2008

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service 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 (QOF) 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 visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection. We carried out an announced inspection on 14th July 2015.

We spoke with a range of staff including GPs, practice nurses, the practice pharmacist, reception staff and the practice manager. We sought views from patients looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing 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.

However not all significant events were fully recorded, investigated and shared with staff. The practice manager assured us new documentation would soon be in use which would improve the content of these events and demonstrate learning from the events. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of clinical meetings recorded in 2015 provided evidence that incidents, events and complaints were discussed. We saw that where it was appropriate actions were taken and protocols adapted to minimise re-occurrence of the incident or complaint. However these actions were not always shared with all staff although staff told us they were always kept well informed of any changes in protocols. Records were available that showed the practice had consistently reviewed and responded to complaints.

Staff informed us that daily checks on the environment and equipment were undertaken. These were formally recorded so staff could verify these checks had been carried out.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of events the practice had titled significant events that had occurred during the previous 12 months. There was evidence that the practice had learned from these and adapted or change procedures as required. Some of these events had occurred outside of the practice and were recorded to ensure staff were aware of the incidents. For example the practice had been notified of a number of infant deaths relating to children at their practice and this had been recorded as a significant event to allow staff to discuss this at staff meetings. When we reviewed the documents the practice used to record SEA we found although the events were fully recorded as being discussed at staff meetings the SEA paperwork did not reflect this detail. The practice manager assured us new documentation would soon be in use which would improve the content of these events and demonstrate learning from the events. She informed us she would ensure the detail was entered on the SEA documentation from the minutes of the meetings and would ensure dates of when incidents had been closed were also fully recorded

Staff spoken with including practice nurses and the practice pharmacist provided recent examples where procedures had changed following investigation of an event.

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. Incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team where relevant.

National patient safety alerts were disseminated by the Clinical Commissioning Group (CCG) or the practice manager to relevant staff. Nursing staff we spoke with gave examples of recent alerts /guidance that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

Staff had access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical, reception and administrative areas. The practice policies and procedures were available electronically for staff. One GP partners was the designated lead for safeguarding however all the partner GPs and senior nursing team had undertaken level three safeguarding training to assist in this role. The practice could articulate the exact numbers of children on their child protection and looked after registers. Staff members we spoke with told us of recent experience of reporting concerns to the safeguarding teams and they provided examples from the past. Staff showed us how information was recorded on the electronic patient record and told us about the other health care professionals they

shared their concerns with, such as the health visitor. The practice worked closely with the AWAKEN project this had been on-going for 12 years and looked at child and young people trafficking issues in the area. The project could also be used for advice and staff told us they knew how to contact the scheme. The scheme had planned dates to attend the practice to carry out update training.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice manager confirmed that only staff who had received training in the role and responsibilities of chaperoning carried out this role. All staff who undertook this role had criminal records check through the Disclosure and Barring Service (DBS). Patients spoken with told us they were aware of the availability of a chaperone if required.

Medicines management

We checked medicines stored in the treatment rooms and fridges at the practice. 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.

The practice employed a pharmacist who worked closely with the Clinical Commissioning Group (CCG) medicine management team to ensure that medicines prescribed to patients were reviewed following receipt of national alerts, followed national guidance and were cost effective. The pharmacist provided a recent example of an audit undertaken to check patients on hypertensive medication were appropriately managed. All changes to prescribing practice and patients prescriptions were authorised by the GPs at the practice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had two nurse prescribers who were appropriately trained to prescribe some medicines. Blank prescription pads were appropriately stored and tracked.

Medicines for use in medical emergencies were kept securely in the treatment room. We were told that stock levels and expiry dates were checked on a regular basis. There was oxygen kept by the practice for use in case of an emergency. The practice also had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly). Staff knew where these were held and how to access them. Oxygen and an automated external defibrillator (AED) were kept by the practice for use in an emergency. These were checked regularly. An AED is a portable device that is used to treat cardiac arrest by sending an electric shock to the heart to try to restore a normal rhythm.

One practice nurse had responsibility for ensuring medicine including vaccines were stored correctly and had not exceeded their expiry date. A tracking system was available to ensure sufficient stock.

The practice was working to install electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist. This reduced the need to use paper prescriptions.

Cleanliness and infection control

We saw the premises were clean and tidy when we visited. There were cleaning schedules in place and cleaning records were kept. Comments recorded by patients on CQC comment cards referred to the practice as being clean, welcoming and hygienic. We saw the results of a recent infection prevention and control (IPC) audit which had been carried out in September 2014, we saw an action plan was on-going for meeting the outstanding actions. Records were also available demonstrating that staff had received training in use of personal protective equipment.

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. Staff received training about infection control specific to their role and those we spoke with understood their role in respect of preventing and controlling infection. We saw that

policies and procedures were up to date, and these were stored on the practice's electronic shared drive. Procedures included the safe storage and disposal of needles and waste products.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were disposable and changed in accordance with a planned schedule. These had recently been changed to disposable after the IPC audit. Nursing staff we spoke with told us about the cleaning they undertook between patient appointments to reduce the risk of cross infection.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). This was planned to be updated in the next month.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment used during minor surgical procedures was single patient use and disposed of in line with manufacturers guidelines after use.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were 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.

Emergency drugs were stored in the treatment room. There was an oxygen cylinder and access to an automated external defibrillator. These were maintained and checked regularly.

Staffing and recruitment

The practice had an appropriate recruitment policy.

We looked at a sample of eight staff recruitment files to see if the practice's recruitment practices were safe. We saw from the employment files for newer members of the staff team that all reasonable checks had been undertaken to ensure these new employees were fit to work with people who were potentially vulnerable. We saw all interview records, references and identification checks were available and all new staff were subject to disclosure and barring checks (DBS).

Professional registrations and insurance details of all professional staff were monitored and checked as required.

Staff told us there were enough staff to maintain the smooth running of the practice and there were 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.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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. All new employees were given basic induction information for the building, which covered health and safety and fire safety.

There was a health and safety policy available for all staff, however this was being reviewed and updated. We were told workplace risk assessments had been undertaken.

Arrangements to deal with emergencies and major incidents

An appropriate business continuity plan (Continuity and Recovery Plan) and supporting risk assessment was in place and up to date. This comprehensive 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

Good

Are services safe?

were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment available. Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and asthma. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a current up to date fire policy in place. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

When patients were first registered with the practice, the nursing team offered a full health check which included gathering information about the patient's individual lifestyle choices as well as their medical conditions. Referral to secondary care was made as required.

The GPs lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the care of patients' different health care needs.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients care and treatments were based on need and the practice took account of a patient's age, gender, race and culture as appropriate. Even though the practice was in a very deprived and disadvantaged area the staff had not become normalised to situations they still reported to GPs and the nursing team where they felt there was a need.

GPs attended regular meetings with the Clinical Commissioning Group (CCG) so they were aware of developments within the local area.

Long term and chronic conditions were assessed and managed through the appointment recall system. This area of work was led by GPs and practice nurses although they both had different areas of responsibility for patient care.

Management, monitoring and improving outcomes for people

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

The practice showed us that clinical audits had been undertaken in the last year and the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients with alcohol dependency, who were discharged from hospital, with medication that did not following NICE guidelines. All patients within the audit were recalled and medication changed where appropriate to reflect the guidance. Staff spoke positively about the culture in the practice around audit and quality improvement

Referral rates to secondary care were monitored to ensure this system was improving outcomes for patients. Attendances at A& E were monitored and the clinical lead nurse rang each patient the day after their attendance/ discharge to establish the reason for the admission and to see whether interventions from the practice would be more effective.

The practice participated in the Quality and Outcomes Framework (QOF) system. This is a system for the performance management of GPs. It is intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing slightly better than the CCG average and other practices nationally. The practice maintained an updated register for patients with a learning disability, a register of patients in need of palliative care and support and having regular multidisciplinary reviews of patients on the palliative care register.

The practice had read coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to

secondary care and other services. 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.

Effective staffing

We spoke with two GP trainees during the visit. They told us they received an extensive induction process prior to joining the surgery. They told us they felt challenged academically but never placed in an unsafe situation. Support was available at all times and all the GPs had an open door policy if they needed support. The trainees told us their appointment times varied now due to their increasing experience and confidence. Protected learning time was in place each week which encouraged them to identify and address their learning needs.

The practice manager was responsible for all checks including Disclosure and Barring Service checks and indemnity cover.

An appraisal system was in place all for clinical and non-clinical staff. The purpose of this was to review staff performance and identify staff development needs for the coming year.

Staff spoken with told us senior staff were supportive of their learning and development needs and they felt well supported in their roles. They said they had undertaken the training needed for their roles.

The GP annual appraisals and revalidation was up to date. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. GPs told us they had protected learning time and opportunity to reflect on their practice, review their training needs and identify areas for development.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and identify where any improvements needed to be made.

Working with colleagues and other services

Care provided to patents at the end of their life was managed by one of the GPs. They aimed to have continuity of care with same GP. Carers were always informed of any decisions made, and the out of hour's provider was notified of patients' palliative status. District nurses were kept informed of relevant information.

One GP at the practice held a Section 12 Certificate under the Mental Health Act 2008. The practice worked within the confines of the local NHS Mental Health process for their patients.

There was involvement with the multi-disciplinary team to discuss unplanned admission to A&E. The practice and another local practice was part of a neighbourhood with a joint patient total of 23000. They employed a nurse to visit patients in hospital and try to move them out of hospital and to their preferred place for care as soon as possible. The nurse also followed up patients after discharge from hospital. The senior nurse at the practice contacted all patients who attended A&E and held unplanned admission's care plans the morning after their attendance to discuss their visit with them and offer support as required.

The practice worked with the Horizon drug and alcohol counselling service and supported detoxification at home if required.

Teenagers and young people who were pregnant and registered at the practice were offered a referral to a family nurse partnership agreement when they reached 16 weeks in their pregnancy. This service offered the person up to four hours per week of professional support until the child was two years old. This covered child care, social issues, housekeeping, health promotion and safety. The practice currently had six mums active on this programme three who were pregnant and three who had already given birth. This support and education process alongside the contraception advice offered by the professional had been shown to decrease second pregnancies in the younger age population in the practice.

The practice was active in supporting the local Springboard service which worked with 200 family members in the local area who were high consumers of probation/police/criminal justice/social services and benefits. They actively worked to assist these patients with their needs to reduce the cost to the local economy.

The practice worked closely with the AWAKEN project, this had been a 12 year arrangement and was concerned with

working to reduce and prevent child trafficking in Blackpool. The practice also used this service for advice and attended AWAKEN case reviews for patients registered with their practice.

Clinical staff also attended quarterly Clinical Commissioning Group learning forums.

Information sharing

The practice used an electronic system to communicate and share information with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, the practice made referrals through the Choose and Book system. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Reception staff were fully trained on the use of the IT systems. Staff knew to keep information about patients confidential and only share this on a need to know basis.

Regular meetings involving the practice manager and non-clinical staff took place to ensure they were fully informed about the systems in place for the running of the service. GPs met regularly with the clinical staff. Information about risks, significant events and patient care issues were discussed to ensure all clinical staff had all the information they need to deliver effective care and treatment to patients. Other health care professionals attended the meetings as needed.

The practice website provided patients with information about the services offered. It also included links to other websites relating to health care organisations. However the practice leaflet needed updating due to changes in staff.

Staff shared information with the out of hour's provider so they were fully informed about patients' needs during the out of hour's period. This enabled continuity of care for patients with a terminal illness, complex mental health issues or those who have in place any advance care instructions. The practice had defined their unplanned admissions and at risk patients care plans and were now able to update them automatically if the patient needs changed or they attended A&E and had become inpatients. This had been shared with their neighbourhood practice and as they shared a nurse they both used the same form for ease and to reduce risk.

Consent to care and treatment

Consent to treatment was obtained by the GP or nursing team for all treatment and procedures. This was recorded on their electronic system and by use of templates embedded in to the system.

The practice ran a family planning clinic and GPs and nurses demonstrated a clear understanding of the use of the Gillick competency. The Gillick competencies help clinicians to identify young people (aged under 16) who have capacity to consent to medical examination and treatment. An example was discussed which demonstrated the use of the Gillick competencies which assessed any risks to a patient and routinely asked safeguarding questions to ensure their welfare.

The relatives / carers of patients with a learning disability were invited to contribute to discussions to establish the patient's best interests. This was in line with principles of the Mental Capacity Act to determine if the patient had capacity to make a decision for themselves or not.

There has been some training about the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The practice had recently moved to an electronic training system and staff were being encouraged to access training as soon as possible. GPs and staff were aware of the principles of MCA through professional practice and information made available to them. DoLS was discussed during clinical meeting so all staff are aware of the requirements of DoLs and the impact this has on patient care. Any patients who were subject to MCA decisions had this recorded in their notes.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice nurses and health care assistants offered appointments from 8 am for people who were at work and staff actively promote NHS health checks. A full range of family planning services were available on site including contraceptive implants and coils.

The practice offered an open sexual health programme to all patients in the area both registered at the practice or elsewhere. This had been set up originally due to high incidence of chlamydia and HIV in the area. People in the area had historically not attended Genito Urinary Medicine (GUM) clinics at the local NHS establishment this service was set up at the practice. The practice was a member of

and followed the guidelines set out by the British Association of Sexual Health and HIV (BASHH). All staff assisting with sexual health matters at the practice had been appropriately trained. Patients accessing this service had separate health records on the electronic system to ensure confidentiality of the person's information. All tests carried out by the service did not contain the person's name and personal details they were all securely managed by use of a personalised code number. This ensured only the person who the test belonged to could access the results.

The practice actively offered HIV screening to all patients and hoped to eventually normalise the test and encourage people to view the condition as any other chronic condition. The practice was able to discuss the number of patients who were HIV positive with us during our inspection.

The practice had achieved the Navajo Kite Mark, which is a certificate of friendliness to lesbian, gay, bisexual and transsexual patients. The Navajo was chosen by those involved at the start of the project in 1999, to pay tribute to the traditions of tolerance, non-discrimination and goodwill that historically formed a central part of the Navajo Nation's belief, including respect being paid to' two-spirit people' whom in our own society we recognise as lesbian, gay, bisexual and transgender people. The practice allowed patients from this group to register with them with the identity they chose to be identified by. This user friendly approach to this group of patients, resulted in other patients asking to join the practice.

The practice had until recently offered sexual health clinics for the local school attendees at lunchtime but due to constraints within the school this clinic had now moved to after school time to accommodate the young people wishing to access the service. The practice offered a separate phone line to young people to book into or to gain advice on sexual health. They found young people liked this process as they didn't have to ask for the clinic they wanted, the person who answered the phone knew and could just offer times.

Young people in the area could register on a scheme called the C-Card project, which enabled them to collect condoms at the reception at the practice on production of their membership card.

Baby clinics were timed to run alongside health visitor clinics within the building. This provided maximum convenience for families and maximised on immunisation rates. GPs routinely carried out six month baby checks on all babies which allowed them to discuss any issues and contraception with the mother.

Staff were proactive in offering flu, pneumonia and shingles vaccinations to those eligible or in at risk group such as those patients over 65 years of age.

The practice pharmacist ran smoking cessation clinics and shared results of their success with reducing the number of patients on the programme who still used cigarettes. This data demonstrated that at four weeks the practice had a 49% success rate which was above the Blackpool average at the same time on the programme of 36%. The pharmacist used social media especially text messaging to communicate with these patients and to allow them to contact the pharmacist for support. Statistics generated for the period 01/04/14 to 03/03/15 during our inspection showed the practice had a 50% success rate for patients who set a quit date actually achieving that date and not smoking. We could not source data for the local area to compare this too accurately.

The nursing team carried out NHS well-being checks during which time they actively promoted good health care. Health promotions leaflets and posters were displayed in the patient waiting area. Opportunistic advice was provided during consultations to patients with obesity or alcohol problems when deemed necessary.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The reception area was separate from the administration area so calls into the practice could not be overheard. The reception desk was at two heights allowing patients in wheelchairs to communicate easily with the reception staff.

Feedback on the patient comment cards we received was very positive about the way they were treated by staff. Patients commented that staff were friendly and caring with a pleasant attitude. They noted that they felt listened to during consultations and that GPs were understanding of their care needs. Patients noted they were always treated with respect. They described the staff as very helpful and the GPs as very good. They said staff went out of their way to make them feel at ease.

We looked at the results of the 2015 GP patient survey. This is an independent survey run on behalf of NHS England. 95% of respondents to the GP patient survey 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, national average was 85.1%. With 95.1% saying the GP gave them enough time against a national average of 86.6%.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability or was on the child protection register/ looked after child.

The practice offered patients a chaperone prior to any examination or procedure. Information on the chaperone service was seen displayed in the reception area and all treatment and consultation rooms.

Care planning and involvement in decisions about care and treatment

Patients whose long term conditions left them at increased risk of hospital admission were covered by the Unplanned Admission Enhanced Service. They had their care plans reviewed regularly to ensure they accurately reflected their current health care needs. An annual review was offered to patients with complex mental health needs with a care plan drawn up as appropriate.

We looked at the results of the 2015 GP patient survey. Which indicated that 86.1% of respondents to the survey stated that the last time they saw or spoke to a GP, the GP was good at involving them in decisions about their care. Against a national average of 81.5%. With 93.6% indicating the nursing tam was good at involving them in their care against a national average of 84.9%

After attendance at A&E the lead nurse rang the patient to discuss their visit and update their care plans or offer assistance as required to ensure the patients' needs were fully met. Any changes to the care plans were automatically updated and shared with relevant service.

Patients' carers were involved in the patients' care planning and decision making to ensure they received the right treatments and level of care. Patients' care needs were regularly reviewed as needed with carer input taken into consideration when making decisions. The practice held a register of carers, this information was also recorded on a patient's notes so they could be directed to carer support agencies. GPs were keen to ensure that carers and advocates had a single point of contact to ensure continuity of care.

Patients spoken with said the nurse or GP explained their treatments and the risks involved and they felt listened to when they discussed their treatment options. Patients said that referrals to secondary care were completed in a timely manner and they were given opportunity to discuss their choices.

Patient/carer support to cope emotionally with care and treatment

Patients and those close to them received the support they needed to cope emotionally with their care and treatment. Longer appointment were offered when needed. Annual reviews were offered for patients with complex mental health needs with care plans put in place as appropriate.

Clinical staff engaged with a local dementia diagnosis and management enhanced service which meant more patients could be diagnoses and managed at the practice by familiar GPs rather than being referred secondary care. An annual review and physical health checks were offered to patients with dementia.

Staff worked with local Drug and Alcohol Teams to support patients with addiction. Alcohol dependant patients could be assisted with a detoxification programme by the GPs at the practice following care plans from the local drug and alcohol team

Good

Are services caring?

For bereaved patients, GPs called relatives to offer their condolences and then offered an appointment for support. Bereavement counselling services were available for family members, and carers and staff could direct them to carer support agencies as required.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. This information was reflected in the services provided, for example screening programmes, sexual health requirements, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

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.

All their registered patients (0.9% of patient population) living in the local residential and nursing care homes within their catchment area had their healthcare needs reviewed and assessed by a GP and a care plan recorded.

The practice worked proactively to support both staff and patients in managing and supporting people with mental health needs. The practice worked closely with a primary mental health care worker who was based locally in the local football club for any advice they required for patients.

Older patients who became housebound were offered timely home visits and there was a robust recall system for annual reviews and other monitoring for patients with chronic diseases and long term conditions. The practice nurses were up to date with management and monitoring of long term conditions. Patients with a learning disability, together with their carers, were offered an annual review with a 30 minute appointment.

The practice held an up to date register of all patients within the practice who had learning disabilities (LD) Their care was reconciled and reviewed annually with the local LD team.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service.

The practice worked with a local organisation Springboard to assist patients who were high consumers of services in the area for example police and probation services to manage the patients with an aim to decrease the cost to the local health economy.

The surgery offered patient suitable sized and appropriate waiting areas. Baby changing and disabled toilet facilities were available.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. Staff told us that they had access to translation service (language line) if needed.

The practice was known locally to be friendly to the local gay, lesbian, bisexual and transgender patients and had achieved Navajo Kite Mark. Patients could be registered with the identity they chose to be identified by.

The practice offered a comprehensive HIV monitoring system hereby they were striving to normalise HIV and encourage staff and patients to think of HIV positive as a chronic disease. They did not actively monitor treatment of HIV but liaised with hospital consultants who were managing their patients on a regular basis. The practice currently had a register of all HIV positive patients registered with them.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. However the practice leaflet was in need of updating to reflect new staff.

The practice phone line were open 8am - to 8pm Monday to Fridays except Friday when they close at 6.30pm.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Appointments are offered between 8.am and 8pm every day except Friday when they offered appointments until 6.30pm. They also offered Saturday morning clinics for long term conditions management. They held seasonal Flu vaccination clinics at certain times of the year. Patients requiring a GP outside of normal working hours were advised to contact the out of hour's service provider urgent care centre. The appointment system was continually monitored and had recently been reviewed and changed in response to patient feedback

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 ringing the practice on the day were offered on the day appointments where available. Children were always seen on the day by a member of the GP team. Patients told us they could always manage to be seen when needed, although one patient said the phones were sometimes busy but if they rang back a little later they managed to get through ok.

Young people could access the sexual health service by mobile number direct to a member of staff who would assist them to book an appointment.

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 and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Investigations into complaints were seen to address the original issues raised and action was taken to rectify problems. We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site and was part of the practice leaflet. However the practice leaflet was in need of updating due to changes in staff.

Staff were clear on the action they would take if they received a complaint. They knew to give patients a copy of the complaint procedure so they were aware of timescales for the investigation of their complaint. A whistleblowing policy was in place. Instances of whistleblowing had not occurred at the practice. Staff told us that if a complaint involved them then they were involved in the investigation, informed of the outcome of the investigation and if required supported to change or improved their performance.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice

Are services well-led?

Outstanding ☆

(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 services and outcomes for patients. Staff we spoke with were eager and enthusiastic to help develop and improve the service. Staff were able to articulate the vision and values of the practice. The GP partners demonstrated enthusiasm and commitment in their discussions with the team during the inspection and had a detailed insight into the different needs and vulnerabilities of their local communities. It was clear they shared this enthusiasm and commitment with all the staff and that they also had this as their ethos. The philosophy of the practice was evident in all our conversations with practice staff. Staff we spoke with held the vision as a personal goal as well as a collective one; they all wanted to ensure the best possible outcomes for their patients.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and the practice staff. We saw evidence that showed the GPs met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

All staff we spoke with demonstrated a cohesive commitment and enthusiasm and were engaged in providing a high quality service. The partner GPs shared their vision of providing holistic quality services to patients.

Governance arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the computer shared drive. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying 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 now 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.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed well when compared with other practices for the local clinical commissioning group and the England average in 2013/14. The practice achieved 889.5% of 900 QoF points available.

Clinical audits were undertaken by the GPs and nurses throughout the year to audit their performance and change practice as required for the benefit of patients they supported. One example was medication reviews for patients currently on Orlistat for weight loss. These patients were investigated to ensure their medication and care plan was effectively managing their condition and was in line with NICE guidance. Outcome from the audit included a consent form to record BMI and weight at the start of the programme and included a target date and target weight.

The practice had arrangements in place for identifying and managing risks.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. The senior staff demonstrated a holistic model of leadership with everyone working towards the same goals, the whole team worked effectively under the leadership of the senior team.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance

Are services well-led?

Outstanding ☆

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

of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

Staff told us where they highlighted issues they were listened to and a solution was agreed as a team.

The practice held a number of various meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

The practice investigated and responded to complaints in a timely manner, and records indicated that complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the issues raised.

Results of surveys, significant events and complaints were discussed at clinical meetings. Patients told us that the practice was patient centred and staff were happy to have patients involved and they could express their opinions at any time to any member of staff and were confident they would be listened to.

There was a virtual Patient Participation Group (PPG) which was proving to be hard to manage so the practice manager had plans to invite members of the virtual PPG to a face to face meeting to try to establish a programme of meetings.

The practice reception staff and patient friends encouraged all patients attending the practice to complete the new Friends and Family Test as a method of gaining patients feedback. Feedback was collated and displayed in the waiting room monthly.

Management lead through learning and improvement

The practice worked well together as a team and supported each other as required.

GPs were all involved in revalidation, training, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities relevant training. Records of staff training and copies of training certificates were available.

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. The practice was a GP training practice with two trainees currently placed with the practice. The practice was recognised by the Deanery as a placement area for GP trainees who required an extension to their training programme. Some of the GPs at the practice were previous trainees within the practice and one trainee told us he was hoping to stay on at the practice after qualifying as a salaried GP.

The practice had completed reviews of significant events, complaints and other incidents and however investigation and learning from these was not always shared with staff at meetings.