Park Parade Surgery

Quality Report

69 Park Parade
Whitley Bay
Tyne and Wear
NE26 1DU
Tel: 0191 252 3135
Website: www.parkparadesurgery-whitleybay.nhs.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive announced inspection at Park Parade Surgery on 10 March 2015. Overall, the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. They were also good at providing services for the six key population groups we looked at during the inspection.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- Risks to patients were assessed and well managed;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Findings from the National GP Patient Survey of the practice, published in January 2015, indicated most patients had a high level of satisfaction with the care and treatment provided;
- Information about the services provided by the practice was available and easy to understand, as was information about how to raise a complaint;
- The practice had satisfactory facilities and was equipped to treat patients and meet their needs;
- There was a clear leadership structure and good governance arrangements. The practice actively sought feedback from patients.

We identified outstanding areas of practice:

- 6.05% of the practice population was made up of patients from the Bangladeshi community. This group of patients had been identified as having a higher incidence of diabetes, heart and respiratory disease. In response to these identified health needs, the practice

Summary of findings

had employed a Bangladeshi support worker to: liaise with patients; encourage their attendance at GP and hospital appointments, offer an interpreting service during consultations, and provide health education to the Bangladeshi community in collaboration with the practice health visitor;
- The practice scored very highly in some areas of the National GP Patient Survey, published in January 2015, when compared to others in their local Clinical Commissioning Group.

However, there were areas of practice where the provider needs to make improvements. Importantly the provider should:

- Introduce a formal system for reviewing new clinical guidance;
- Obtain their own defibrillator, in line with current guidance and national standards;
- Ensure non-clinical staff carrying out chaperone duties undergo a Disclosure and Barring Service (DBS) check, or carry out a risk assessment to determine which staff roles do not require one.

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 nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to the provision of effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local Clinical Commissioning Group (CCG). Staff had received training appropriate to their roles and responsibilities. The practice had made suitable arrangements to support clinical staff with their continuing professional development. There were systems in place to support effective multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

Nationally reported data showed patient outcomes were mostly either in line with, or better than the local CCG and national averages. Findings from the National GP Patient Survey, published in January 2015, showed 96% of patients would recommend the surgery to someone new to the area. This was above the local CCG average of 84% and national average of 78%. Patients said they were treated well and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to

Summary of findings

information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were either in line with, or better than the local CCG and national averages. Findings from the National GP Patient Survey, published in January 2015, showed most patients were satisfied with practice opening hours, telephone access, and appointment availability. For example, 93% of the patients who responded to the survey said they were satisfied with the practice's opening hours. This was above the local CCG average of 82% and national average of 76%. The majority of the 50 patients who completed CQC comment cards were satisfied with access to appointments.

Services had been planned to meet the needs of the key population groups using the practice. The practice had satisfactory facilities and was appropriately equipped to treat patients and meet their needs. There was an accessible complaints procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them.

Are services well-led?

Good

The practice is rated as good for providing well led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice clinical team demonstrated good professional values and had a clear ethos which underpinned their work. They were working hard to improve the services they provided to patients by taking, for example, steps to identify more suitable premises. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for. The practice had a range of policies and procedures covering its activities. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

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 patients.

Nationally reported Quality and Outcome Framework (QOF) data for 2013/14 showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 0.7 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

The practice provided proactive, personalised care to meet the needs of older people. They provided a range of enhanced services including, for example, allocating a named GP who was responsible for overseeing the care and treatment received by the practice's older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those who needed them.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with chronic obstructive pulmonary disease (COPD). This was 2.1 percentage points above the local CCG average and 4.8 points above the England average.

The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Clinical staff had the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

Summary of findings

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Nationally reported QOF data for 2013/14 showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages.

Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Where comparisons allowed, we found the delivery of childhood immunisations was higher when compared with the overall percentages of children receiving the same immunisations within the local CCG area. For example, with regard to seven of the eight childhood immunisations for children aged five years, the numbers who received these were above the local CCG averages. New mothers had access to regular baby clinics, and ante-natal appointments were offered by healthcare professionals attached to the practice. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients (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. Nationally reported QOF data for 2013/14 showed patient outcomes relating to the conditions commonly associated with this population group were above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with cardiovascular disease. This was 4.6 percentage points above the local CCG average and 12 points above the England average.

The needs of this group of patients had been identified and steps had been taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. For example, patients could order repeat prescriptions and book appointments on-line. Extended hours appointments were available until 7:00pm four evenings a week. Health promotion information was available in the waiting area and there were links to self-help information on the practice website. The practice provided additional services such as travel vaccinations and minor surgery.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Systems were in place to identify patients, families and children who were at risk or vulnerable. Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to patients with learning disabilities. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with learning disabilities. This was 10.3 percentage points above the local CCG average and 15.9 points above the England average.

Staff worked with relevant community healthcare professionals to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and took action to protect vulnerable patients. Staff were aware of their responsibilities regarding information sharing, recording safeguarding concerns and contacting relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with mental health needs. This was 4.1 percentage points above the local CCG average and 9.6 points above the England average.

The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register. The practice regularly worked with other community healthcare professionals to help ensure patients' needs were identified, assessed and monitored.

Summary of findings

What people who use the service say

During the inspection we spoke with two patients from the practice's patient participation group (PPG). We also reviewed 50 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were satisfied with the care and treatment they received. Most patients told us they received a good service which met their needs.

Findings from the National GP Patient Survey of the practice, published in January 2015, indicated most patients had a high level of satisfaction with the care and treatment provided. For example, of the patients who responded to the survey:

- 99% said the last GP they saw, or spoke to, was good at listening to them. (This was above both the local CCG average of 92% and the national average of 88%);
- 96% said the last GP they saw or spoke to was good at giving them enough time. (This was above both the local CCG average of 90% and the national average of 86%);
- 97% said the last GP they saw or spoke to was good at treating them with care and concern. (This was above both the local CCG average of 86% and the national average of 82%);
- 93% said the last GP they saw or spoke to was good at explaining tests and treatments. (This was above the local CCG average of 87% and the national average of 82%);
- 100% said they had confidence and trust in the last GP they saw or spoke to. (This was above both the local CCG average of 95% and the national average of 93%).[TJ1]

These results were based on 122 surveys that were returned, out of a total of 264 sent out. The response rate was 46%.

Areas for improvement

Action the service SHOULD take to improve

The practice should:

- Introduce a formal system for reviewing new clinical guidance;
- Obtain their own defibrillator, in line with current guidance and national standards;
- Ensure non-clinical staff carrying out chaperone duties undergo a Disclosure and Barring Service (DBS) check, or carry out a risk assessment to determine which staff roles do not require one.

Outstanding practice

The practice had employed a Bangladeshi support worker to: liaise with patients; encourage their attendance at GP and hospital appointments, offer an interpreting service during consultations, and provide health education to the Bangladeshi community in collaboration with the practice health visitor. The involvement of the support worker had led to better health outcomes for the Bangladeshi community.

The practice scored very highly in some areas of the National GP Patient Survey, published in January 2015, when compared to others in their local Clinical Commissioning Group.

Park Parade Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team also included a practice manager and a GP.

Background to Park Parade Surgery

Park Parade Surgery is a busy practice that provided care and treatment to 4404 patients of all ages, based on a Personal Medical Services (PMS) contract agreement for general practice. The practice is part of NHS North Tyneside Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Whitley Bay area. The practice serves an area that has lower levels of deprivation for children than the England average. Deprivation levels for people in the over 65 age group were higher than the England average. The practice's population includes more patients aged under 18 years, and over 65 years of age, than the local CCG and England averages.

The practice provides services from the following address which we visited during this inspection:

69 Park Parade, Whitley Bay, Tyne and Wear. NE26 1DU.

The practice occupies what was formerly a private dwelling which has been adapted to meet patients' needs. The premises are fully accessible to patients with mobility needs. Park Parade Surgery provides a range of services and clinic appointments including, for example, clinics for patients with diabetes and women requiring ante-natal care. The practice consists of two GP partners (both male) and two salaried GPs (both female), a practice manager, two practice nurses, a healthcare assistant and administrative and reception staff. The practice also employed a Bangladeshi support worker.

When the practice is closed patients can access out-of-hours care via Northern Doctors Urgent Care and the NHS 111 service.

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.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Detailed findings

• 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 10 March 2015. During this we spoke with a range of staff including: both GP partners; the practice manager; a practice nurse, the practice's Bangladeshi support worker and members of the reception and administrative team. We spoke with two patients from the Patient Participation Group (PPG) who visited the practice on the day of our inspection. We observed how staff communicated with patients who visited, or telephoned the practice on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed 50 Care Quality Commission (CQC) comment cards that had been completed by patients who use the practice.

Are services safe?

Our findings

Safe Track Record

When we first registered this practice, in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about this practice.

The practice used a range of information to identify potential risks and to improve patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with, or who had completed comment cards, raised no concerns about safety at the practice.

We saw that records were kept of significant events and incidents. We reviewed a sample of the records completed by staff during the previous 12 months, as well as the minutes of meetings where these were discussed. These records showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff.

Twelve significant events had taken place during 2014. The sample of significant event records we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent reoccurrences. For example, one of those we looked at involved a patient being sent to the wrong surgical assessment unit, due to a misunderstanding that had occurred during the initial referral telephone call. We saw that the GP who had made the referral had reviewed their practice to prevent this from happening again. The practice manager had reported the incident via the local safeguard incident risk management reporting system (SIRMS) so that an appropriate review could take place. We confirmed the incident had been discussed in a practice meeting to provide opportunities for the whole staff team to learn from the incident.

The staff we spoke with were aware of the system in place for raising issues and concerns. The practice also reported relevant incidents to the local CCG, using the local SIRMS. Arrangements had been made which ensured national patient safety alerts were disseminated by the practice manager to the relevant team member. This enabled these staff to decide what action should be taken to promote patient safety, and to mitigate any risks. (Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice.)

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. However, the practice's 'Safeguarding People Who Use The Service From Abuse' policy was out-of-date and in need of review. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. One of the salaried GPs acted as the designated lead role for safeguarding children and adults. Staff we spoke with said they knew which GP acted as the safeguarding lead.

Most of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Both nurses had completed Level 2 training which was more relevant to the work they carried out. A GP we spoke with told us both clinical and non-clinical staff had completed adult safeguarding training delivered to the standard recommended by the local CCG. The administrative staff we spoke with confirmed they too had completed safeguarding awareness training. All of the staff we spoke with demonstrated a good understanding of how to protect and safeguard patients.

A chaperone policy was in place and information about this had been displayed throughout the practice. The patients

we spoke with said they knew they could access a chaperone if they needed one. All the clinical and non-clinical staff who carried out chaperone duties had undertaken chaperone training. The practice manager told us the GPs mainly used the nurses and healthcare assistant as chaperones but that occasionally, reception staff had taken on this role. We found that some of the non-clinical staff had not undergone a Disclosure and Barring Service (DBS) check. The practice manager agreed to review this matter following the inspection.

Regular multi-disciplinary team meetings took place. The GPs met with health visitors, and other healthcare professionals, to review patients considered to be at risk and, where appropriate, to share any relevant information. Processes were in place for taking decisions about how the practice should respond to missed appointments, and for highlighting children at risk on their medical records.

Medicines Management

Medicines were safely stored in a locked cupboard and unused prescription pads were kept in a locked room. We confirmed the practice did not hold any controlled drugs. (Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation, and stricter legal controls are applied to prevent them from being misused, obtained illegally or causing harm.)

Refrigerator temperatures were checked daily to help ensure medicines requiring cold storage, such as vaccines, were stored correctly. We found all vaccines stored within the practice's two refrigerators were within their expiry dates. Records had been kept of the checks carried out.

The practice had effective arrangements for monitoring the expiry dates of emergency medicines and for ordering new supplies. The GPs monitored the expiry dates of the medicines they kept in their own doctor's bag and were prompted by the nursing team from time to time. We found all emergency medicines were in date, as were the sample of medicines we checked in the doctor's bag.

Patients were able to order repeat prescriptions in a variety of ways, including by visiting the practice, ordering by telephone, on-line and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Reception staff handled telephone requests for repeat prescriptions competently and safely. They were clear about the processes they should follow, including checking that the number of authorised repeat prescriptions had not been exceeded. Repeat prescription requests were signed by GPs after each surgery session. The receptionist we spoke with said the repeat prescription processes worked well.

The practice had implemented the Electronic Prescription System (EPS). This enables prescribers, such as GPs and nurses, to send prescriptions electronically to a pharmacy, where this is the patient's preferred choice. The system also helps reduce prescriber errors.

A system was in place for responding to any medicine related safety alerts received by the practice. One of the GPs we spoke with told us the alerts were forwarded to the doctors and the practice pharmacist, and checks were carried out to make sure the practice complied with the relevant ones. However, we identified there was no audit trail to evidence that actions had been taken in all cases in response to medicine alerts.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. A member of the reception team carried out regular health and safety inspections, including checking that the premises were clean. The patients we spoke with, and those who commented on this in the CQC comment cards they completed, told us the premises were always clean. Cleaning services were provided by an external contractor who worked to a cleaning schedule which had been recently been reviewed. The cleaning cupboard was well stocked, clean and tidy. The nurse we spoke with was clear about her responsibilities with regards to keeping the consultation room they worked in clean and hygienic.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be replaced on a regular basis.

Spillage kits were available to enable staff to deal safely with spills of bodily fluids. A member of the reception team we spoke with was clear about how bodily spills should be handled. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. Clinical rooms contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Are services safe?

Arrangements had been made for the safe handling of specimens and clinical waste. For example, reception staff were clear about how to handle specimens so that the spread of infection was reduced. All of the waste bins we saw were visibly clean and in good working order.

The practice had a Legionella policy and had recently arranged for an external company to carry out a risk assessment. This showed the water system was low risk and recommended that staff dismantle and clean spray nozzles on a monthly basis. The practice manager told us this recommendation was being addressed. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

Infection control procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. The practice had an infection control lead who also provided guidance and advice to staff when needed. The infection control lead told us they had recently completed advanced infection control training, and were supporting and training the practice's healthcare assistant to take a more active role in infection control management.

The infection control lead told us an infection control risk audit had been completed approximately 18 months ago, to help identify any shortfalls or areas of poor practice. They said that following these changes had been made to improve infection control arrangements. For example, the practice had changed their privacy screens from material to paper so they could be easily replaced. Clinical staff had been reminded of the need to make sure the right types of sharps were placed in the correct sharps bin. The practice's infection control arrangements were being reviewed following the advanced infection control training recently completed by the lead nurse.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. Minor surgery was carried out at the practice. Appropriate arrangements had been made for the disposal of single-use surgical instruments. Equipment was inspected and regularly serviced. For example, there had been a recent check of the practice's fire equipment. The sample of fire extinguishers we looked at had last been inspected in November 2014. A fire risk assessment had also been completed. Arrangements were also in place which ensured other equipment used in the day-to-day business of the practice was subject to regular testing to ensure it was safe to use and in good working order.

Staffing & Recruitment

The practice had a recruitment policy which had been recently reviewed. This policy provided clear guidance about the pre-employment checks that should be carried out for new staff. However, the policy had not been updated to reflect changes in legislation. For example, the Independent Safeguarding Authority had been disbanded a number of years ago.

A range of pre-employment checks had been undertaken to help make sure only suitable staff were employed. We looked at the records for a member of staff appointed before the practice registered with the Care Quality Commission (CQC). We saw they had undergone a Disclosure and Barring Service (DBS) check and references had been obtained. This person had submitted a curriculum vitae and application form which provided details of their previous employment. Evidence was available confirming new employees had received an induction. All GPs, nurses and non-clinical staff had a NHS Smart card (containing an identity photograph) which meant their identity had been verified under the NHS Employment Check Standards process.

The GP partners had each undergone a DBS check as part of their application to be included on the National Medical Performers' List. (All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate.) We checked the General Medical and Nursing and Midwifery Councils registers and confirmed all of the clinical staff working at the practice were licensed to practise.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. For example, staff had carried out regular 'housekeeping' audits to check the premises were safe and hazard free. An up-to-date fire risk assessment was in place and provided evidence the practice had assessed the potential risks to staff and patients. The most recent fire drill took place on 24 March 2015, and two staff had recently completed Fire Marshall training. All staff had completed fire safety training in 2013 and the local CCG was looking to source an alternative training provider to deliver

this training to practice staff in the future. We checked the building and found it to be safe and hazard free. None of the patients we spoke to raised any concerns about health and safety. The practice completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and promote learning within the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. For example, there was an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. The plan covered the actions to be taken to reduce and manage a range of potential risks. The practice manager told us staff had received training in cardio-pulmonary resuscitation (CPR). However, the CPR training for the GPs was overdue, but this was outside of the control of the practice. A planned training session was due to take place for the GPs in April 2015. There was equipment available for use in emergencies including an anaphylaxis kit and oxygen. However, the practice did not have a defibrillator. One of the GPs advised that the practice had an arrangement with a local pharmacy opposite the practice to access their defibrillator should this be necessary. According to current external guidance and national standards, practices should be encouraged to have defibrillators.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. All clinical staff had access to local guidelines, as well as guidelines from the National Institute for Health and Care Excellence (NICE). A GP we spoke with told us that although there was no formal system in place for reviewing and, where appropriate, updating the practice's clinical guidelines, clinicians did discuss relevant clinical issues at practice meetings.

From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines and local protocols. Patients' needs were reviewed as and when appropriate. A member of the nursing team told us they had access to a range of chronic disease management templates. They said they used these to record details of the assessments they had carried out and any agreements reached with patients about how they should manage their condition. Information about commonly found long-term conditions was available to enable clinicians to provide patients with the guidance they needed to manage their health.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas including mental health, diabetes, asthma and chronic obstructive pulmonary disease (COPD). (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.) Staff had responsibilities for carrying out a range of designated roles. These included, for example, making sure emergency drugs were in date and fit for use, and monitoring performance in achieving the recommended levels of care and treatment set out in the Quality and Outcomes Framework (QOF).

Nationally reported QOF data for 2013/14 showed the practice had achieved 99.6% of the total points available to them for providing recommended treatments to patients with common health conditions. This was 2.8 percentage points above the local Clinical Commissioning Group (CCG) average and 6.1 points above the England average. The practice had met all but three of the minimum standards for QOF including, for example, those covering asthma, COPD, epilepsy and heart failure. The practice had just missed achieving full points for the clinical indicator relating to depression and the public health indicator relating to smoking. However, the practice had only obtained 83.7% of the points available to them for the public health indicator relating to blood pressure. This was 10.2 percentage points below the local CCG average and 11.2 below the England average. The practice was able to provide us with feedback on this particular indicator which seemed reasonable to the inspection team. The practice was not an outlier for any QOF (or other national) clinical targets.

Clinical audits had been carried out to ensure that patients were receiving recommended care and treatment in the areas covered by the QOF. This included a two-cycle audit by one of the GP partners to check that patients over 40 years of age with an episode of non-visible haematuria (blood in their urine), who could be at risk of cancer, had been treated in line with the practice's guideline, and appropriately referred. The guideline indicated patients should firstly undergo a repeat urinalysis to exclude urinary tract infection as the cause of the non-visible haematuria (NVH) in their urine. The initial audit had identified that six of the patients (14%) who had NVH had not undergone a repeat urinalysis, despite being reminded of the need to do so by the practice. As a result of the audit, patients underwent repeat testing and were referred in line with the practice's guidance. The GP who carried out the initial audit reminded staff about the practice guidelines. A re-audit was then carried out in 2014/15, and this confirmed a reduction of 7% in the number of patients without a repeat urinalysis. We confirmed that a second two-cycle clinical audit had also been carried out. One of the GPs we spoke with acknowledged the practice's recent focus on developing emergency care plans, monitoring emergency admissions and providing data requested by the local CCG, had meant the clinical team had completed fewer clinical audits than it would ideally have preferred to. They told us this was an area where the practice could give further consideration to making improvements.

Effective systems were in place which helped to ensure patients received prompt safe care and treatment. For

Are services effective?

(for example, treatment is effective)

example, all discharge and other advisory letters, and all test results were processed by the medical secretary, and then forwarded to the relevant GP to ensure appropriate action was taken.

Effective staffing

The team included medical, nursing, managerial and administrative staff to help ensure the practice had the right numbers of skilled, competent and experienced staff. The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. For example, the majority of GPs had completed Level 3 child protection training. The GP with lead responsibilities for minor surgery had completed annual updates to ensure they retained and developed their skills and competencies. This GP had also completed additional training in sport medicines and providing acupuncture. Another GP had completed a recognised qualification in sexual and reproductive health. Three of the four GPs had completed DRCOG which is the Royal College of Obstetricians and Gynaecologists exam for non-specialists who work in women's health. A member of the nursing team had completed diplomas in diabetes, asthma and COPD management. The nurse who spoke with us confirmed they had completed training in a range of areas relevant to their role and responsibilities including, for example, cervical screening and contraception. They also had completed regular updates in other areas such as smoking cessation and immunisations.

All the GPs were up-to-date with their annual, continuing professional development requirements and had dates for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.) Both GPs we spoke with said their re-validation was planned for the early part of 2016.

Appropriate indemnity arrangements were in place for the GPs. A GP we spoke with said the team had access to clinical support via the local CCG peer group, and through informal networking meetings organised via the local hospital trust. There were effective arrangements for the appraisal of staff.

Appropriate arrangements had been made to ensure the practice was appropriately staffed. The GP partners told us the doctors covered each other's leave. A GP rota was in place. This helped to ensure the GP team was aware of who was on duty and what any cover arrangements were. The nurse we spoke with said that any nursing cover required for holidays was provided by the other nurse working extra hours. Similar arrangements were in place for the non-clinical staff. There was limited use of locum staff and there was a process in place for arranging cover when this was needed. These arrangements helped to ensure that sufficient numbers of staff were always rostered on duty.

Working with colleagues and other services

The practice had developed positive working relationships, and forged close links with other health and social care providers, to help them co-ordinate care and meet patients' needs. The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end-of-life care needs. These meetings were attended by the GPs, practice nursing staff as well as local healthcare professionals, such as health visitors and midwifes. Some practice staff had external roles which encouraged partnership working. For example, one of the GP partners acted as the locality lead for the local CCG.

Practice staff also worked with other service providers to meet patients' needs and manage complex cases. The practice received written communications from local hospitals, the out-of-hours provider and the 111 service, electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. The administrative staff we spoke with told us they had been trained in how to use the system. This enabled scanned documents such as hospital letters to be retained in patients' electronic records.

The practice used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider, which ensured the practice received written information about any contact it had had with their

Are services effective?

(for example, treatment is effective)

patients. The practice shared information about patients with complex care and treatment needs with the out-of-hours and urgent care providers. These arrangements helped ensure important information about patients' needs was shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

The practice had a consent protocol which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do if a patient lacked the capacity to make an informed decision. The practice's clinical staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. One of the GP partners we spoke with demonstrated a clear understanding of consent and capacity issues. They were able to clearly explain when consent was necessary, and knew what to do, and who to contact, if a patient lacked capacity to consent to their care and treatment. The same GP told us the practice's IT system provided clinicians with a reminder to consider carrying out the Gillick competency test for appropriately aged young people. Evidence was available that consent was obtained for minor surgery carried out the practice.

Health Promotion & Prevention

The practice offered all new patients a health check with a member of the nursing team. This included providing them with a helpful new patient welcome pack. These checks covered a range of areas including height, weight and blood pressure. The practice also offered NHS Health Checks to all patients aged between 40 and 75 years of age. The practice chose not to sign up to the NHS Health Checks enhanced scheme in 2013/14. However, we were told that Well Women and Well Men health checks were available on request. We confirmed that a protocol was in place for managing concerns identified in any healthcare checks that were carried out. The practice offered patients opportunistic health screening, particularly in the areas of smoking, obesity and exercise. This helped to ensure patients were able to benefit from lifestyle advice and the early identification of potential health problems.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had obtained 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The practice manager told us that, over the last year, 37.5% of the patients who received smoke cessation advice had given up smoking. The practice had also obtained 100% of the points available to them for providing cervical screening to women. This was 0.5 percentage points above the local CCG average and 2.5 points above the England average. The practice told us that, in the last five years, 75% of eligible women had taken up the offer of cervical screening.

The practice was good at identifying patients who needed additional support and were proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients. The data indicated, for example, that 100% of patients with dementia had received a range of specified tests six months before, or after being placed on the practice's register. This was 17.7 percentage points above the local CCG average and 19.8 points above the England average.

The practice offered a full vaccination programme, and acted as a Yellow Fever Centre. Data reviewed by the CQC identified no concerns in relation to the percentage of patients aged 65 and over who had received a seasonal flu vaccination. Similarly, there were no concerns in relation to the percentage of higher risk patients with identified chronic diseases identified by national campaign that received the seasonal influenza vaccination.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the National GP Patient Survey of the practice, published in 2015. The evidence from these sources showed the majority of patients were satisfied with how they were treated and with the quality of the care and treatment they received. For example, of the patients who responded to the Survey: 96% said the last GP they saw, or spoke to, was good at giving them enough time (this was above both the local CCG average of 90% and the national average of 86%); 99% said the last GP they saw, or spoke to, was good at listening to them (this was above both the local CCG average of 92% and the national average of 88%); 97% said the last GP they saw, or spoke to, was good at treating them with care and concern, (this was above the local CCG average of 86% and the national average of 82%). Surveys results regarding the practice nurses also exceeded the local CCG and national averages.

We received 50 completed Care Quality Commission (CQC) comment cards. The feedback received from these patients was mostly positive. Most patients said they received a good service that met their needs. We also spoke with two patients from the practice patient participation group (PPG) on the day of our inspection. Both confirmed practice staff treated them with dignity, respect and compassion.

During the inspection we observed that all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Patients were able to access a private room if they wished to talk confidentially to reception staff.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey of the practice, published in January 2015, showed patients were positive about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example: 80% of respondents said their GP involved them in decisions about their care, (this was above the local CCG average of 79% and the national average of 74%); 93% felt the GP was good at explaining treatment and results, (this was above the local CCG average of 87% and the national average of 82%). Surveys results for the practice nurses in these areas also exceeded the local CCG and national averages. Where patients had made comments on the CQC comment cards they completed, they all confirmed they were involved in decisions about their care and treatment. This was echoed by the comments made by the PPG members we spoke with.

Practice staff told us translation and interpreter services were available for patients who did not have English as a first language. The single largest non-English speaking group were from the Bangladeshi community. The practice had catered for their needs by providing them with access to a Bangladeshi speaking support worker. Providing these services helps to promote patients' involvement in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by practice staff. Where patients had made comments on the CQC comment cards they completed, they all confirmed they were supported to cope with the emotional impact of their illness. This was also confirmed by the PPG members we spoke with. Patients were provided with access to same-day appointments if they had urgent needs. This enabled their needs to be met quickly when necessary.

We observed staff in the reception area treating patients with kindness and compassion. Notices and leaflets in the waiting room sign-posted patients to organisations offering support with coping with loss. Clinical staff also referred patients struggling with loss and bereavement to these services.

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 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 had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients. They kept a register of patients aged over 75 to help ensure they knew whose these patients were so they could plan their care effectively. The practice had written to each patient aged 75 years and over explaining which GP would act as their named doctor.

A risk assessment tool had been used to profile patients according to the risks associated with their conditions. The practice manager told us this information was reviewed weekly to help identify the patients most at risk of an emergency admission into hospital. The practice also had an at risk register of adults who had the most complex needs and 2.09% of these patients (the required number) had an emergency care plan in place. We were told these were reviewed every three months. Monthly admissions avoidance meetings were held, involving local health and social care professionals, to prevent, where possible, emergency admissions into hospital.

The practice nursing team was responsible for delivering most of the chronic disease care and treatment needed by patients. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD), an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team. The practice provided full diabetic care to 90% of their diabetic patients. The Quality and Outcomes Framework (QOF) data for 2013/14 showed the practice had obtained 100% of the points available to them for providing recommended care and treatment for diabetic patients. For example, the data showed 100% of the medical records of newly diagnosed patients contained evidence they had been referred to a structured education programme, within six months of being placed on the practice's diabetic register. This was 6.7 percentage points above the local CCG average and 4.9 points above the England average.

Of the patients who participated in the National GP Patient Survey for the practice, published in January 2015: 89% said the last nurse they saw was good at explaining tests and treatment, (this was above both the local Clinical Commissioning Group (CCG) average of 81% and the national average of 77%); 93% said they had confidence and trust in the last nurse they saw or spoke to, (this was above the local CCG average of 89% and the national average of 86%).

The QOF data for 2013/14 showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care. (This was in line with the local CCG average and 3.3 points above the England average.) The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. All at-risk children and their families had an allocated GP lead who was responsible for reviewing and monitoring their healthcare. Pregnant women were able to access a weekly antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages. Child health surveillance post-natal appointments were offered to new mothers at six weeks, by one of the GPs. QOF data for 2013/14 showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

The practice offered a full range of immunisations for children. The health visitor attached to the practice provided a drop-in clinic for parents with children under five years. This was attended by the practice's Bangladeshi

Are services responsive to people's needs?

(for example, to feedback?)

support worker who provided support to new mothers from the Bangladeshi community. Where comparisons allowed, we found the delivery of childhood immunisations to babies aged 24 months, and children aged five, was higher when compared to the overall percentages of children receiving the same immunisations within the local CCG area.

The practice had planned their services to meet the needs of the working age population, including those patients who had recently retired. They provided an extended hours service until 7:00pm four days a week to facilitate better access to appointments for working patients. The practice website provided patients with information about how to book appointments and order repeat prescriptions. QOF data for 2013/14 showed the practice had obtained 100% of the points available to them, for providing recommended care and treatment to patients who had been diagnosed with the conditions most commonly affecting this population group. For example, the data showed that 97.6% of patients with hypertension (high blood pressure) aged over 16, had a record of intervention recorded in their medical records during the previous 12 months. This was 4.9 percentage points above the local CCG average and 6.5 points above the England average.

Tackle inequity and promote equality

The staff we spoke with demonstrated an understanding of the impact that deprivation had on patients' health and wellbeing, and spoke clearly of the steps they were taking to meet the needs of patients affected by this. The practice had made suitable arrangements to identify and meet the needs of patients whose circumstances made them vulnerable, for example, patients with learning disabilities and those with complex health conditions. Nationally reported QOF data for 2013/14 indicated the practice had provided recommended care and treatment to this group of patients. The practice had obtained 100% of the total points available to them for providing care and treatment to patients with learning disabilities. (This was 10.3 percentage points above the local CCG average and 15.9 points above the national average.)

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English, to access the practice. The practice manager told us 6.05% of the practice population were patients from the Bangladeshi community. They said this community had been identified as having a higher incidence of diabetes, heart and respiratory disease and, in response to these identified health needs, the practice had employed a Bangladeshi support worker. The support worker told us they had been trained to liaise with patients, encourage their attendance at appointments (GP and hospital), offer an interpreting service during consultations and provide health education to the community in collaboration with the health visitor attached to the practice. Healthcare posters translated into Bangladeshi were available in the reception area. The future of this outstanding area of work is in doubt as following a general review of all Primary Medical Services contracts by NHS England the specific funding for this work with the Bangladeshi community is threatened. The practice is doing all it can to protect and preserve this service.

Where practicable, the premises had been adapted to meet the needs of patients with disabilities. For example, patients using wheelchairs had access to ground floor clinical and consultation rooms, and the reception area was located on the ground floor. The practice had recently updated its loop system, which helps hard of hearing patients hear better, following feedback from the Practice Participation Group (PPG). However, the GP partners acknowledged the premises were not ideal. They told us that although the practice had a ground floor toilet, it was not accessible to wheelchair users. Due to the location of the practice, disabled parking was not provided. Information about disabled access had been placed on the practice website so that new patients could assess whether any disability needs they had could be met. The partners told us they continued to make efforts to identify more suitable premises, though to date, they said they had been unsuccessful in their attempts to do this.

Access to the service

Appointments were available from 08:30am to 7:30pm four days a week and between 08:30am and 6:00pm one day a week. Providing extended hours makes it easier for working age patients and families to obtain a convenient appointment. Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice website. The practice offered a variety of different appointments, such as same-day and routine appointments. Each GP also provided morning and afternoon telephone consultations. Routine appointments could be booked up to 13 weeks in advance. The practice operated an on-call duty doctor system. The duty GP was

Are services responsive to people's needs?

(for example, to feedback?)

responsible for assessing and dealing with any same-day urgent requests. One of the GPs told us children and babies were always given priority and would be seen on the same day contact was made with the practice.

Most of the 50 patients who completed comment cards expressed no concerns about the practice's appointment system. Two patients raised concerns about accessing emergency appointments. However, both of the PPG members we spoke with said they also had no concerns about access to appointments.

Overall, feedback from the National GP Patient Survey of the practice, published in January 2015, indicated the practice performed well in meeting patients' expectations regarding access to appointments. Of the patients who participated in the survey: 93% said they were satisfied with the practice's opening hours, (this was above the local CCG average of 82% and national average of 76%); 82% said they were able to get an appointment to see or speak with someone, (this was just below the local CCG and national averages of 86%); 94% said they found it 'easy' to get through on the telephone to someone at the practice, (this was above both the local CCG average of 81% and the national average of 71%); 98% said they found their last appointment to be convenient, (this was above both the local CCG average of 93% and the national average of 92%).

The practice's website provided patients with information about how to access out-of-hours care and treatment, including appropriate emergency care. When the practice was closed, patients telephoning them were re-directed to the 111 service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice manager was the designated person responsible for handling complaints. Information was available to help patients understand the complaints process. The practice website provided patients with information about how to complain. Information about how to complain was also available within the reception area of the practice, as was a suggestions box.

The practice had maintained a record of all of the complaints they had received. There had been two complaints during the previous nine months. Both had been investigated and feedback was provided to the complainants. Where the practice had identified they had not performed as well as they should have, the complainant was offered an apology and the opportunity to come in and discuss the findings of the investigation. This complaint had also been reviewed under the practice's significant event reporting procedures to enable shared learning to take place. The other complaint had remained unresolved, as no response had been received from the complainant to the practice's response. However, following the investigation, the practice concluded that, on this occasion, they had acted properly. From the information supplied by the practice we were able to confirm they responded appropriately to concerns raised by patients. The complaints record contained evidence that lessons were learned following each complaint.

Are services well-led?

(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 charter which described their key commitments to patients. The practice provided the inspection team with a clear statement about the services they delivered to the key population groups we looked at. In addition to this, a set of aims and objectives had been agreed. These included, for example: to provide the best possible standard of medical care; ensure a safe and effective surgery environment; treat all patients and staff with dignity, respect and honesty and maintain robust information governance procedures to protect our patient records. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. However, we did identify, apart from the patient charter, there was no other information about the practice's vision and strategy on its website.

Although the practice were unable to show us anything in writing which set out their strategy for the future, it was clear the GPs partners had spent a significant amount of time and energy considering the potential threats to their business and their capacity to develop in the future. We were told those risks included working in premises that were not ideal and hampered their ability to offer patients better care. The partners told us they had attempted to secure new premises on a number of occasions, but had been unsuccessful in doing so. The partners also expressed concerns that the Primary Medical Services funding review might mean that the Bangladeshi support worker service could be under threat if funding was withdrawn.

Governance Arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. We were also able to confirm that arrangements had been made to respond to individual patient risks such as, for example, ensuring that at-risk children and their families had a named GP. Also, the risk assessment planning tool used by the practice meant they were able to identify the most vulnerable patients at risk of unplanned admissions into hospital. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the practice, and were in the process of being reviewed, and where necessary updated, at the time of our visit.

Regular meetings, involving staff at all levels, were held to enable effective decision-making and shared learning to take place. For example, there were regular multi-disciplinary meetings which provided opportunities for practice staff and community healthcare professionals to assess the needs of patients with palliative care needs.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard expected. The practice had carried out some clinical audits to help improve patient outcomes.

The practice manager had made arrangements to monitor its clinical performance. Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data and agree areas for improvement. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) Regular checks of the practice disease registers were carried out to make sure patients received recommended levels of care and treatment.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. For example, one of the GP partners acted as the lead for minor surgery. There were GPs leads for the most commonly found long-term conditions. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and were able to describe how they took an active role in trying to ensure patients received good care and treatment. Staff told us they would feel comfortable raising concerns with the practice manager or the GP partners.

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

Are services well-led?

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

Practice staff had made arrangements to actively seek and act on feedback from patients and staff. For example, patients were invited to complete a Friends and Family Test (FFT) following a visit to the practice. Feedback from the December and January 2015 FFT surveys showed that, out of the 51 responses received, 47 patients indicated they were 'extremely likely' to recommend the practice to family and friends, and two said they were 'likely' to do so. The practice had also carried out their own comprehensive survey in 2014. This showed the majority of patients were happy with most aspects of the service. For example, 84.69% of patients said they would definitely recommend the practice to someone who had just moved into the area.

The practice had an active patient participation group (PPG) that included six core members. (The main aim of promoting the development of a PPG is to help the practice engage with a cross section of the practice population and obtain their views.) Information about how to join the group was available in the patient reception area and on the practice website. The PPG aimed to meet every three months. Although there had been four meetings in the last seven months, there had been no meetings between December 2013 and September 2014. However, staff told us that between January and March 2014, PPG members had email contact about the practice's patient survey results and to agree their final report for 2013/14.

We looked at the PPG report for 2014/15. This clearly described what the PPG's priorities were and what progress had been made in relation to them. For example, the PPG had stated it wanted to encourage members of the practice's large Bangladeshi community to join their meetings. We saw steps had been taken towards achieving this goal. The two members of the PPG we spoke with told us they had a good working relationship with the practice, and felt that the practice team explained any changes in the health economy and listened to any concerns they had.

The practice had gathered feedback from staff through regular staff meetings and the use of staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. The staff we spoke with told us they had opportunities for continuous learning to enable them to maintain and develop their skills and competencies. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. The practice demonstrated their strong commitment to learning by providing opportunities for undergraduate medical students to spend time at the practice. One of the GPs also acted as a GP appraiser. (A GP appraiser is a senior doctor who carries out assessments of GPs performance to inform the Responsible Officer's revalidation recommendation to the General Medical Council). Reviews of significant events had also taken place and the outcomes had been shared with staff via meetings and on the practice intranet. This helped to ensure the practice improved outcomes for patients through continuous learning.