Berkley Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at Berkley Medical Centre on 13 October 2014. The overall rating for the practice is good. We found the practice to be good in the effective, safe, caring, responsive and well-led. We found the practice provided good care to people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health.

Our key findings were as follows:

- Patients were protected from the risk of abuse and avoidable harm. The staff we spoke with understood their roles and responsibilities and there were policies and processes in place for safeguarding children.
- Patients received care and treatment to support good outcomes which promoted a good quality of life.
- Staff were caring and treated patients with dignity and respect.
- The practice had taken action to improve the appointment booking process.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice proactively sort feedback from staff and patients and this was acted upon.

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

In addition the provider should:

- Review how, in the absence of specific training, assurance is gained in relation to the knowledge and understanding of staff, for example, infection control, Mental Capacity Act and safeguarding vulnerable adults.
- A risk assessment should be in place when making decisions non the necessity of DBS checks.
- Gain assurance from the property management that appropriate, maintenance and risk assessments are in place.

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 safe. The practice used a range of polices and procedures to support safe practice. Policies and procedures were in place to ensure staff had the necessary knowledge and understanding in relation safeguarding vulnerable groups. The staff we spoke with were aware of their responsibility.

There was no risk assessment in place to identify staff groups requiring DBS checks.

A system was in place and staff understood their responsibilities to raise concerns, and report incidents and near misses.

Are services effective?

Good

The practice is rated as good for effective. The staff we spoke with were aware of national guidance. People's needs were assessed and care was planned and delivered in line with current legislation. Generally staff had received training appropriate to their roles. The management and monitoring of further training needs was not always evident. The staff we spoke with had received an annual appraisal and felt supported in their role. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Overall the analysed data from the national patient satisfaction survey showed patients rated the practice in line with other practices in the area. Patient's feedback was that they were treated with compassion, dignity and respect. Information was available to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. There was improved access to the practice following feedback, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system.

Are services well-led?

Good

The practice is rated as good for well-led. Staff were clear about the vision and their responsibilities in relation to the delivery of good

Summary of findings

care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, however regular governance meeting had not taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sort feedback from patients and this had been acted upon. The practice had an active patient participation group (PPG).

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 offered proactive, personalised care which included home visits where appropriate. The practice were taking part in a Clinical Commissioning Group (CCG) pilot scheme where the practice nurse or health care assistant completed home visits for patients whose age or fragility meant they were unable to access the practice. This was to monitor and support long term conditions and health checks.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice nurses and health care assistant regularly reviewed the long term condition register to ensure patients were reminded when a review of their condition and treatment was required.

The practice was taking part in a Clinical Commissioning Group (CCG) pilot scheme where the practice nurse completed home visits for patients whose age or fragility meant they were unable to access the practice. We saw good outcomes for people who were supported to manage and monitor their long term conditions.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Immunisation clinics were in place. The nurses we spoke with were aware of their performance figures and uptake was in line with the national average. Appointments were available outside of school hours and the premises was 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 the working-age population and those recently retired. The needs of the working age population, those recently retired and students were considered with early evening appointments being available. The practice was proactive in offering online services for ordering prescriptions as well as offering health checks for this group of patients.

Summary of findings

People whose circumstances may make them vulnerable

Good

Staff knew their responsibility in relation to safeguarding children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of service hours.

Patients with learning disabilities were not routinely offered an annual physical health check.

People experiencing poor mental health (including people with dementia)

Good

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice had a system for referring patients experiencing poor mental health to community services for support.

The nurse we spoke with told us that they had been supported to gain the necessary knowledge and understanding to refer patients to community services when necessary. We saw that contact details for the mental health team were available.

Summary of findings

What people who use the service say

Prior to the inspection we provided the practice with a comments box and cards inviting patients to tell us about their care. We received 25 responses all of which were positive in relation to their care and treatment. The feedback from patients confirmed that staff at the practice treated people with dignity and respect. They told us that generally appointments were available.

We looked at the results from the national patient survey. We saw that 85% of patients who responded to the survey described their overall experience of the surgery as good. This was above the regional average.

We spoke with a member of the patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They told us that the

Areas for improvement

Action the service SHOULD take to improve

- Seek assurance from the building management that appropriate maintenance and risk assessments are in place.
- Review how, in the absence of specific training, assurance is gained in relation to the knowledge and understanding of staff, for example, infection control, Mental Capacity Act
- A risk assessment should be in place when making decisions on the necessity of DBS checks.
- Review the impact on the accessibility of appointments as well as seek patients views on the practice closing during normal working hours.

Berkley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a GP, a nurse and a second CQC inspector.

Background to Berkley Practice

Berkley Medical Centre is based in the Walsall Clinical Commissioning Group (CCG) The practice provides primary medical services to approximately 4200 patients in the local community.

On the day of our inspection the practice had three GPs. Additional staff included a practice manager, one nurse practitioner and one practice nurses, a health care assistant and seven administrative staff who supported the practice

The practice offered a range of clinics and services including asthma, diabetes, COPD and Immunisations.

The Badger Group provided primary medical services to the practice patients outside of normal surgery hours.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was 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.

This provider had not been inspected before and that was why we included them.

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)

Prior to the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an

Detailed findings

announced visit on 13 October 2014. During our visit we spoke with a range of staff including two GPs, the practice manager, members of the nursing team and administration support staff.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and there was a system in place to report incidents and near misses.

We saw that meetings for clinical staff took place weekly where incidents and significant events were discussed. We saw minutes of these meetings which confirmed this. This showed the practice had managed the sharing of incident data consistently. Meetings for all staff working at the practice were less frequent with no formal schedule in place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents and records of these were made available to us. A slot for significant events was on the practice weekly clinical meeting agenda. There was no recording of how appropriate learning had taken place and that the findings disseminated to relevant staff. Staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

National patient safety alerts were received via email and disseminated by the practice manager to appropriate staff.

Reliable safety systems and processes including safeguarding

There were policies and procedures in place for safeguarding children. The staff we spoke with told us that training on safeguarding children had been completed. The practice manager confirmed that training had been completed and that all staff had received training relevant to their role. The practice manager informed us that clinical staff had received training in this area. However there had been no training for non-clinical staff.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children who had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

The practice manager explained the system in place to highlight vulnerable patients on the practice's electronic records system. This included information so staff were aware of, for example, children subject to child protection plans. They told us that staff were using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged.

A chaperone policy was in place and details were visible in the waiting room. Receptionists would act as a chaperone if nursing staff were not available. Chaperone training had not been undertaken to ensure that all staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

We saw that a selection of medicines that may be required for use in an emergency were available. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored appropriately. There was a system for ensuring medicines were kept at the required temperatures.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a policy in place for prescribing, including repeat prescribing. We saw that information for arranging repeat prescriptions was available to patients in the waiting room and via the practice leaflet.

A member of the nursing staff was qualified as an independent prescriber. They discussed confidently their clinical practice and gave examples of how they kept up to date with regulations.

Good

Are services safe?

Cleanliness and infection control

An infection control policy and supporting procedures were available for staff to refer to. A practice nurse was the named lead for infection control. There was an infection control training tool available to all staff. However this had not been completed. We did not see that infection prevention and control training had been completed by the infection prevention and control lead at the practice. We observed the premises to be clean and tidy. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gel was available in the waiting area along with hand hygiene guidance.

We saw that following an infection control audit completed in 2013 all flooring had been changed and sinks updated to ensure compliance with the 'Code of Practice on the prevention of infections and related guidance'.

Legionella is a germ found in the environment which can contaminate water systems in buildings. The practice manager told us that regular water checks were completed by the landlords of the building and that a legionella risk assessment had been completed in 2014. There were actions required following the risk assessment, the practice were unable to confirm that the actions had been completed and the risk to legionella had been reduced.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments, this included home visits. They told us that all equipment was calibrated regularly and we saw contracts were in place which confirmed this. Portable electrical equipment had been tested with in the last three years. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

There had been no new staff recruited to the practice for a number of years. The records we looked at did not contain the appropriate criminal records checks via the Disclosure and Barring Service (DBS). The practice manager told us that all of the clinical staff had checks and we were provided with some evidence of this following the inspection. There had been no DBS checks for non-clinical staff. When making a decision on the necessity of DBS checks a risk assessment should be completed which takes into account the work staff do. There was no risk assessment in place. We have received confirmation from the provider that checks have been requested where appropriate. We have asked the provider to send us confirmation that DBS checks have been completed and that a risk assessment are in place when the decision has been taken not to carry out those checks.

The practice manager told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

Berkley Medical Practice were not the owners of the health centre. The practice manager told us that there was a central contract for the management of the building. There was no practice policy to ensure appropriate annual and monthly checks of the building and environment were in place. The practice manager was confident that the landlord of the build would have these in hand. However they did not have assurance that appropriate risk assessments, for example fire had been completed and where up to date.

Internal monitoring of safety and responding to risk was evident from incident reporting process which were discussed at weekly clinical meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The records we viewed showed staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency. Records we saw confirmed these were checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Not all potential risks had been considered or mitigating actions recorded to reduce and manage the risk. For example, loss of building or guidance for staff on loss of IT equipment whilst replacement was arranged.

Good

Are services safe?

Berkley practice were not the owners of the health centre. The practice manager told us that there was a central contract for the management of the building. Fire risk assessments and evidence of fire drills were not available or actions required to maintain fire safety

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence. A GP told us new and updated guidance was discussed at weekly clinical meetings. The practice manager told us of the procedure for the dissemination of patient safety alerts.

The practice used computerised systems to identify patients with complex needs. There was a system in place for patients to have their needs assessed and care planned in accordance with best practice.

We saw no evidence of discrimination when making care and treatment decisions Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race did not impact upon this decision-making. A health care assistant we spoke with was knowledgeable about their scope of practice and described the internal referral process when faced with situation outside of their remit

Management, monitoring and improving outcomes for people

We found that people's care and treatment outcomes were monitored. The practice used the Quality and Outcomes Framework to assess its performance. Staff had a system for checking that routine health checks were completed for long-term conditions such as diabetes. Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection, alerts management and medicines management. Weekly clinical meeting were in place to enable a consistent approach to reviewing and monitoring. However regular meetings for non-clinical staff were not in place.

In order to manage and monitor the care delivery, treatment and support of patients, for example those receiving palliative care regular multi-disciplinary meetings were in place.

The practice had a system in place for completing clinical audit cycles and we saw examples of clinical audits that had been undertaken. There were completed audits where the practice was able to demonstrate the changes resulting since initial audit commenced. There was an opportunity to discuss the outcomes of clinical audits at the weekly clinical meetings.

The practice were participating on a CCG initiative for home visits by the nursing team. The staff told us that although they were involved in the pilot this was their normal practice where nurses and the health care assistant regularly visited patients. The pilot had enabled the practice to further develop this service. The nursing staff were knowledgeable about the practice population and gave examples of how home visits had improved outcomes for patients. For example there was an increase of patients with a dementia diagnosis.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed a selection of staff training records and saw that all staff had access to mandatory courses such as annual basic life support. In the absence of a training matrix it was difficult to confirm what and when training had taken place and what training was required for each role.

Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council. The GPs had received annual appraisals and revalidation was planned for 2015.

The staff we spoke with said they had annual appraisals which identified learning needs. We were told that staff found the appraisal process a worthwhile experience where they had the opportunity to discuss and issues, concerns and training needs.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice manager discussed the process for relevant staff passing on, reading and actioning any issues arising from communications with other care providers on the day they

Are services effective?

(for example, treatment is effective)

were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held weekly clinical meetings to discuss the needs of complex patents for example those with end of life care needs or children on the at risk register. However multidisciplinary team meetings for the whole staff group were not routinely scheduled.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through 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). Staff reported that this system was effective and gave patients choice when scheduling their appointment.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff we spoke with were confident in the use of the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The staff we spoke with were aware of the importance of patient consent to care and treatment, although there had been no formal training or competency assessments to ensure that all staff were up to date with their knowledge in relation to the Mental Capacity Act 2005.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. This was advertised in the practice leaflet. The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 23% of patients in this age group took up the offer of the health check.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. Health promotion literature and guidance was available in the waiting room. We saw that health care initiatives were advertised, for example shingles vaccines. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Health promotion talks and seminars were arranged for the PPG groups of the three practices in the health centre. A PPG member told us that the information from the seminars was shared in the local community.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the practice on patient satisfaction. This included information from the national patient survey. Data from the national patient survey showed the practice was rated 'in the middle range' for patients rating the practice as good or very good. The practice was also 'in the middle range' for waiting time to be seen. In a survey completed by the practice 88% of patients said they were satisfied treated with care and concern.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 25 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed that patients did not always respond positively to questions about their involvement in planning and making decisions about their care and treatment with the results falling below the regional average. For example, data from the national patient survey showed 66% of practice respondents said the GP involved them in care decisions and 80% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 99% of patients said they were sufficiently involved (excellent, good or satisfactory) in making decisions about their care.

The staff we spoke with were aware of the importance of patient consent to care and treatment, although there had been no formal training or competency assessments to ensure that all staff were up to date with their knowledge in relation to the Mental Capacity Act 2005.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The practice survey, 2014, information we reviewed showed patients views had been sort on support received from the practice. For example, 64% of respondents to the practice survey said that after seeing the GP they understood their problem or illness. The remaining understood 'to some extent'.

Staff told us families who had suffered bereavement were called by their usual GP. If necessary or appropriate the call would either be followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. GPs at the practice engaged regularly with the Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last four years which enabled continuity of care and accessibility to appointments. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes to those patients who needed one. For example, the practice was proactive in the care of its patients who required a home visit. We saw that for patients whose health or fragility prevented them from coming to the surgery, home visits were available. This included home visits by the nurses and health care assistants. This supported patients with the management and monitoring of long term conditions. We were given examples of positive outcomes for patients where nursing and health care assistant home visits had contributed to health improvements.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient satisfaction survey and in discussion with the Patient Participation Group (PPG). An example of this was the change to the appointment booking process.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online viewing and ordering of prescriptions. Translation services were available to support patients whose first language was not English

The premises and services were appropriate to meet the needs of people with disabilities. A hearing loop was available. Consideration had been given to breastfeeding mothers.

Access to the service

Information was available to patients about appointments in the practice leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Recent changes had been made to the appointment system. This was following feedback from patients. Since the introduction of the new system patients had been surveyed to assess their satisfaction. The appointment system ensured that patients could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. The practice was not open on a Thursday afternoon. We discussed this with the practice manager. They told us that an answer phone message directed patients to an alternative care provider to ensure they were able to access care when the practice was closed.

The practice's extended opening hours on a Monday evening until 19:45. This was particularly useful to patients with work commitments. Details of the extended opening hours could be found in the practice leaflet and the practice website.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system; this was available in the practice leaflet and website.

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

When speaking the GPs and staff at the practice there was a clear vision to deliver high quality care and promote good outcomes for patients. The practice manager and staff we spoke with articulated the values of the practice. All were confident and knowledgeable when discussing dignity, respect and equality. When speaking to the GPs, practice manager and staff the importance of quality was evident.

Governance arrangements

There were a number of policies and procedures in place in relation to governance at the practice. We looked at a selection of these policies and procedures. There was no system in place to confirm that staff had read and understood the policies. The policies and procedures we looked at had been reviewed and were up to date.

In the absence of regular team meetings it was not clear how governance arrangements, issues and updates were disseminated amongst the practice staff in a timely manner.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QOF data was regularly reviewed in order to maintain or improve outcomes.

Leadership, openness and transparency

There was a leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. They told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the GPs or practice manager.

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

The practice had gathered feedback from patients via patient satisfaction surveys and complaints. We looked at the results of the national annual patient survey 61% of patients agreed that the experience of making an appointment was good. In response to feedback from patients the appointment process had been redesigned. The practice were in the process of surveying patients on their satisfaction with the new process.

The practice had an active patient participation group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. We spoke with a representative of the PPG. They told us that a GP and practice manager attended all meetings. We were told the practice were receptive to feedback from the group. We saw that there had been consultation with the group on the feedback from the patient satisfaction survey.

The staff we spoke with told us that there was an 'open door culture' at the practice and that they could raise concerns and give feedback where necessary. There was no formal process in place to gather feedback from staff, for example staff satisfaction surveys.

Management lead through learning and improvement

A schedule of risk assessments and audits were in place, for example infection control. Where areas for improvement had been identified an action plan had been instigated.

All incidents, significant events and complaints were logged. Actions taken and lessons learnt were recorded. The practice manager told us that these events were discussed at the weekly clinical meeting.

The GPs and practice manager were aware of the areas in the national patient survey where the need for improvement had been identified. They discussed with us the consideration and actions identified to make improvements to the service.