Brunton Park Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 an announced comprehensive inspection at Brunton Park Health Centre on 10 February 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. It was also good for providing services for the six key population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was appropriately recorded and reviewed;
- Risks to patients were assessed and well managed;
- The practice was clean, 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 that they were involved in decisions about their care and treatment;
- Information about the services provided and how to raise any concerns or complaints, was accessible and easy to understand;
- Patients said they found it easy to make an appointment and urgent same-day access was available;
- The practice had good facilities and was well equipped to treat patients and meet their needs;
- There was a clear leadership structure and staff felt supported by management. The practice actively sought feedback from patients.

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

- 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;
- Consider carrying out a risk assessment to determine which emergency drugs are not required by the practice.

Summary of findings

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 risks 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 partners and practice manager 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. However, we identified non-clinical staff carrying out chaperone duties had not undergone a Disclosure and Barring Service (DBS) check.

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 risks relating to effective. 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 arrangements to support clinical staff with their continuing professional development. There were systems in place to support 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

The practice is rated as good for providing caring services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to caring. Patients said they were treated well and were involved in making decisions about their care and treatment. The practice had made arrangements to ensure patients' privacy and dignity was respected.

Summary of findings

Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff 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.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to responsive. Services were planned to meet the needs of the key population groups registered with the practice. Patient feedback about the practice was generally good. The practice was taking steps to reduce emergency admissions to hospital for patients with complex healthcare conditions, and older patients had been allocated a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system, and evidence demonstrating the practice responded quickly to any issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to well led. The leadership and management of the practice ensured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. 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 day-to-day activities. Systems were in place to monitor and, where relevant, improve the quality of 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 Outcomes Framework (QOF) data (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, QOF data showed the practice had achieved 100% of the total points available to them for providing patients with heart failure with the recommended care and treatment. This was 4.1 percentage points above the local CCG average and 2.9 points above the England average.

The practice offered proactive, personalised care to meet the needs of older people. They provided a range of enhanced services including, for example, 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.

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 (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, QOF data showed the practice had achieved 100% of the total points available to them for providing patients with diabetes with the recommended care and treatment. This was 6.5 percentage points above the local CCG average and 9.9 points above the England average.

The practice was taking steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All the patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been completed for each patient. Practice nurses had received 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

Nationally QOF reported data (2013/14) showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These were both above the England averages (i.e. 0.9 and 1.2 percentage points respectively) and were in line with the local CCG averages.

Systems were in place for identifying and monitoring children who were considered to be at risk of harm or neglect, and for following up any children who failed to attend for childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Where comparisons allowed, we saw 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, eight of the ten childhood immunisations given to children aged five years were above each local CCG average.

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.)

Nationally reported QOF data (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 3.3 percentage points above the local CCG average and 6.9 points above the England average.

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients, such as being able to order repeat prescriptions and book appointments on-line. Extended hours appointments were available until 8:30pm one evening a week. Health promotion information was available in the waiting area. The practice provided additional services such as dietary advice and minor surgery.

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.

Nationally reported QOF data (2013/14) showed patient outcomes relating to the conditions commonly associated with this population group were mostly 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 learning disabilities. This was 10.1 percentage points above the local CCG average and 15.9 points above the England average.

The practice kept a register of patients with learning disabilities and used this information to ensure they received an annual healthcare review and other relevant checks and tests. Staff worked with members of the multi-disciplinary team 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. Staff understood their responsibilities regarding information sharing, the recording of safeguarding concerns and how to contact 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 (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 experiencing poor mental health. This was 3.6 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 and used this to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register, in agreement with the patients and, where relevant, their carers. Staff regularly worked with other relevant professionals to help ensure patients' needs were identified and addressed.

Summary of findings

What people who use the service say

During the inspection we spoke with three patients and reviewed 44 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 for the practice, published in 2015, indicated most patients had a good level of satisfaction with the care and treatment they received. For example, of the patients who responded to the survey:

- 91% said the last GP they saw, or spoke to, was good at listening to them. (This was above the national average of 88%);
- 84% said the last GP they saw or spoke to was good at giving them enough time. (This was slightly below the national average of 86%);
- 87% said the last GP they saw or spoke to was good at treating them with care and concern. (This was above the national average of 82%);
- 79% said the last GP they saw or spoke to was good at explaining tests and treatments. (This was slightly below the national average of 82%);
- 96% said they had confidence and trust in the last GP they saw or spoke to. (This was above the national average of 93%).

These results were based on 103 surveys that were returned from a total of 261 sent out. The response rate was 39%.

Areas for improvement

Action the service SHOULD take to improve

- 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;
- Consider carrying out a risk assessment to determine which emergency drugs are not required by the practice.

Brunton Park Health Centre

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 included a GP and a specialist adviser with a background in practice management. A second CQC inspector was also in attendance.

Background to Brunton Park Health Centre

Brunton Park Health Centre is a busy city practice providing care and treatment to 4312 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Newcastle North and East Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the north and east areas of Newcastle.

The practice serves an area with lower levels of deprivation affecting children and people aged 65 and over, when compared to other practices in the local CCG, and the England average. The practice's population includes more patients aged under 18 years, and more patients aged 65 and over, than other practices in the local CCG area.

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

Princes Road, Brunton Park, Newcastle-upon-Tyne, Tyne and Wear, NE3 5NF.

The premises are purpose built and provide fully accessible treatment and consultation rooms for patients with mobility needs. Brunton Park Health Centre provides a range of services and clinics, including for example, for patients with asthma, diabetes and heart failure. The practice consists of four GPs (one male and three female), a practice manager, a senior practice nurse, a practice nurse, a healthcare assistant and a team of administrative and reception staff. Three of the GPs are partners and one is a salaried GP.

When the practice is closed patients can access out-of-hours care via Northern Doctors, 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

Detailed findings

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?

• 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 February 2015. During this we spoke with a range of staff including: one of the GP partners; the previous practice manager and the newly employed practice manager; a practice nurse, a health visitor who was attached to the practice and members of the administrative and reception team. We spoke with four patients including a member of the practice's Patient Participation Group (PPG). 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 44 Care Quality Commission (CQC) comment cards that had been completed by patients.

Good

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 been notified of 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 how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts (NPSA), and comments and complaints received from patients. The practice manager said they received all NPSAs via email, and then emailed them to the wider practice group so that appropriate action could be taken by the right member of staff. Alerts were also discussed at practice meetings and there was an expectation that absent staff would read the minutes produced.

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 raised no concerns about safety at the practice. Records were kept of significant events and incidents. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. 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. Staff we spoke with were aware of the system in place for raising issues and concerns. We saw evidence which confirmed appropriate learning from significant events and complaints had taken place and that the findings were disseminated to relevant staff. We spoke to staff about how the practice learned from safety incidents, and also looked at some of the records that had been kept. In the information supplied to us before the inspection, we found the practice had recorded three significant events/ incidents between May 2014 and January 2015. Although the Quality Outcomes Framework (QOF) does not specify how many significant events should be reported on, we think the rate of significant event reporting could be improved through the proactive identification of events that would strengthen the practice's arrangements for improving safety. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually.)

In one of these, a member of the practice team had not correctly answered all of the questions asked of them by the ambulance service. This resulted in inappropriate transport being sent to a patient's home. We saw that a detailed and comprehensive record had been kept of how the practice handled this. The record included details of the actions taken by the practice and what lessons had been learnt to prevent a reoccurrence. We saw that, following the incident, the practice manager had discussed the outcomes with relevant staff to help promote learning. This demonstrated the practice had taken the matter very seriously and had liaised with relevant stakeholders to address the issues raised. The outcome of the incident had been discussed at the partners' weekly meeting to ensure that appropriate action had been taken.

An annual significant event meeting took place. We were told this review helped to ensure that the practice had taken appropriate action in relation to the significant events that had taken place. The practice also reported incidents to the local CCG, using the local safeguarding incident reporting system.

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. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. There were designated staff who had lead roles for safeguarding children and adults. Staff we spoke with said they knew who the safeguarding leads were.

Staff had completed safeguarding training relevant to their role and responsibilities. The GPs had completed child protection training to Level 3 as part of their local CCG

Good

Are services safe?

'Time-in Time-out' training sessions. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. The practice nurses had also completed Level 3 child protection training. Staff we spoke to were aware of adult safeguarding issues and confirmed they had received training delivered by the local CCG safeguarding lead. Staff were clear about how they would handle any potential concerns.

A chaperone policy was in place and information about this was displayed in the reception area. The practice manager told us the GPs mainly used the nurses and healthcare assistant as chaperones but that occasionally, during extended hours opening, reception staff had taken on this role. However, they also told us that the non-clinical staff had not undergone a Disclosure and Barring Service (DBS) check. A risk assessment had not been completed to determine which staff roles required a DBS check. (These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Chaperone training for non-clinical staff had been delivered by one of the practice nurses who had completed training delivered by the local CCG.

Patients' records were kept on an electronic system. This system stored all the relevant information about patients, including scanned copies of communications from hospitals. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out). Arrangements were in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations or other healthcare related checks. Practice staff used their multi-disciplinary team (MDT) meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information. The health visitor we spoke with told us they had regular informal contact with practice staff to share any concerns or issues.

Staff were able to easily access the practice's policies and procedures. The GP we spoke with told us they were able to access safeguarding information via their desktop computer. This helped to ensure that, when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines Management

Arrangements were in place to regularly monitor the GPs' prescribing practice. A pharmacist from the Prescribing Support Unit attended the practice for one session per week. The GP we spoke with told us the pharmacist carried out various audits, which we saw evidence of, to make sure medicines were being used effectively. They also provided the practice with advice and support.

Emergency medicines were stored securely. They included, for example, medicines for the treatment of a life-threatening allergic reaction and emergency oxygen. Arrangements were in place for emergency medicines to be checked regularly to make sure they were within their expiry date and suitable for use. All the medicines we checked were in date. The GP we spoke with told us the partners had decided not to carry emergency drugs when carrying out home visits. We found the practice was not stocking some of the recommended emergency medicines. The practice manager told us they had not carried out a risk assessment to determine which emergency medicines they should keep at the practice, or in doctors' bags, when carrying out visits.

A process was in place to handle medicines safety alerts. We were told these were forwarded to the practice pharmacist for processing, and that any decisions about whether action needed to be taken would be reviewed during the monthly practice clinical meetings.

Patients were able to order repeat prescriptions using a variety of ways such as by telephone, online and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. We observed reception staff dealing effectively with requests for repeat prescriptions.

A system was in place which helped to ensure patients who were receiving prescribed medicines were regularly reviewed. The GP we spoke with told us these reviews were

carried out at least annually. Plans had been made for one of the practice nurses, who was completing a non-medical prescribing course, to carry out medicine reviews for patients with chronic diseases.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. Patients told us the practice was always clean. Notices reminding patients and staff of the importance of hand washing were on display in toilets and other relevant areas. The local council was responsible for carrying out cleaning at the practice. We saw evidence that quarterly cleaning audits carried out by the council were shared with the practice.

Infection control policy and procedures were in place and they covered a range of key areas such as, for example, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow. The policy had recently been reviewed. A comprehensive infection control risk assessment and audit had recently been completed in order to identify any shortfalls or areas of poor practice. A detailed action plan, with timescales for completion, had been prepared to address the shortfalls identified.

The practice had a designated infection control lead. This person confirmed they had recently completed advanced training to enable them to carry out this role effectively. We were told other staff had also completed infection control training.

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 regularly changed or cleaned. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Written instructions were in place informing staff how to do this. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order. A legionella risk assessment had been carried out by the local water company in 2013. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming, where appropriate, the calibration of equipment had been regularly carried out.

Practice staff monitored the safety of the building to ensure patients were not put at risk. Regular checks of fire equipment had taken place. For example, an up-to-date fire risk assessment was in place. Weekly fire alarm tests were carried out by an external contractor. The practice had an evacuation plan which informed staff how the building should be evacuated in the event of an emergency. The last recorded fire drill had taken place in 2013. We were told a subsequent drill had taken place, but there was no documentary evidence to confirm this. We checked the building and found it to be safe and hazard free. None of the patients we spoke to had any concerns about their safety when visiting the practice.

Staffing & Recruitment

The practice had a set of recruitment policies and procedures which provided clear guidance about the pre-employment checks that should be carried out on staff. Pre-employment checks had been undertaken to help make sure only suitable staff were employed. For example, written references and full employment histories had been obtained. Staff's NHS Smart cards contained a recent identification photograph and their identities had been verified under the NHS Employment Check Standards process. We checked the General Medical and Nursing and Midwifery Councils records and confirmed all of the clinical staff were licensed to practice. Disclosure and Barring Service (DBS) checks had been carried out for relevant staff in line with their duties and responsibilities, with the exception of those non-clinical staff who carried out occasional chaperone duties. A risk assessment to determine which staff should undergo a DBS check had not been completed.

Systems were in place which helped to ensure there were enough staff on duty to maintain the smooth running of the practice and to meet patients' needs. Staff meetings were

Good

Are services safe?

used to discuss staffing shortfalls and to decide what action needed to be taken to address them. The practice manager told us the GPs and nurses usually covered for each other. This meant there was little use of Locum GPs which helped promote better continuity of care for patients. The GP we spoke with confirmed that succession planning had taken place to ensure the practice remained appropriately staffed following planned staff retirements.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. For example, a risk assessment screening tool had been used to identify patients at risk of an unplanned admission to hospital. Steps were being taken to complete emergency care plans to help prevent older patients and patients with long-term conditions experience unnecessary admissions into hospital. Information about patients with palliative care needs had been entered onto an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet their needs.

The practice carried out significant event reporting where concerns about patients' safety and well-being had been identified. Appropriate arrangements were in place to learn from these and to promote learning within the team.

Arrangements to deal with emergencies and major incidents

The risks associated with anticipated events and emergency situations were recognised, assessed and managed. The practice had an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Staff had contributed to the plan and were able to easily access it if needed. Staff had received training in cardio-pulmonary resuscitation (CPR). Emergency equipment was available, including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment and we were able to confirm that it was regularly serviced and well maintained. An emergency medicines kit was also available within the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to easily access National Institute for Health and Care Excellence (NICE) guidelines. 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. Patients' needs were reviewed as and when appropriate. Clinical responsibilities were shared between the clinical staff and arrangements were in place for staff to take lead responsibilities for particular areas of practice.

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. The GP and practice nurse we spoke with told us there was a process in place for developing specific templates to reflect the needs of the practice and their patients, and ensure that these were in line with NICE guidelines.

Practice staff had the knowledge, skills and competence to enable them to respond appropriately to patients' needs. For example, the practice nurse we spoke with confirmed they had received the training they needed to carry out their roles and responsibilities. All staff had received safeguarding training to help them keep patients safe. The GPs had provided evidence of continuing learning as part of their annual appraisal arrangements.

Patients we spoke with said they felt well supported by the GPs and nursing staff and received a good service. This was also reflected in most of the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with the clinical staff showed the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas including, for example, diabetes, women's health and responsibility for monitoring the practice's Quality and Outcomes Framework (QOF) performance. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles such as making sure emergency drugs were up-to-date and fit for use.

The practice manager and GP partners monitored how well the practice performed against key clinical indicators, such as those contained within the QOF. Clinical and non-clinical staff were responsible for coding information to enable judgements to be made about compliance with QOF targets.

We saw evidence the practice had been involved in clinical audit activity to help improve patient outcomes. For example, one of the audits we looked at had examined whether eligible housebound patients with Chronic Obstructive Pulmonary Disease (COPD) had received appropriate care and treatment in line with NICE guidelines. (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema). We saw that the original findings had been re-audited to establish whether the practice continued to offer appropriate care and treatment to these patients. The practice had also participated in a range of clinical audits instigated by the local CCG focussing on, for example, cellulitis, dermatology, non-emergency orthopaedic and cardiology referrals. We saw evidence confirming the outcomes of these audits had shown the practice had followed relevant care pathways. A one-cycle clinical audit had been carried out by a medical student placed at the practice focussing on the NICE guidelines for the management of patients with chronic kidney disease taking a recommended prescribed medicine. The GP we spoke with told us the practice's recent focus on developing emergency care plans had meant the clinical team had completed fewer audits than it would ideally have preferred to. They told us this was an area where the practice could make further improvements.

The practice was proactive in managing, monitoring and improving outcomes for patients. Practice staff told us they used the information collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. Nationally reported data, taken from the QOF for 2013/14, showed the practice had overall achieved 100% of the total points available to them for providing recommended

Good

Are services effective?

(for example, treatment is effective)

treatment to patients with the commonly found health conditions covered by the scheme. (This was 5.1 percentage points above the local Clinical Commissioning Group (CCG) average and 6.5 points above the England average).

Other examples of good QOF performance showed that: 100% of eligible patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of the test results. (This was 4.4 percentage points above the local CCG average and 8.5 points above the England average); 93.5% of eligible patients with a diagnosis of heart disease had had this confirmed by an echocardiogram or by specialist assessment, three months before or 12 months after being entered onto the practice's disease register. (This was 2.6 percentage points below the local CCG average and 1.8 points below the England average.) The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets.

Effective systems were in place which helped to ensure patients received prompt care and treatment. For example, the practice manager told us that on receipt, hospital letters (paper) were immediately reviewed and key information was highlighted by the data quality administrator, and then were passed to the GPs for checking and actioning. We did not identify any concerns with this process.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The GPs had completed additional training to help them deliver the care and treatment they provided. For example, one of the GPs had an interest in child and women's health and had completed a recognised qualification in obstetrics and gynaecology. Another GP, also with an interest in women's health, had completed a diploma in sexual and reproductive healthcare. This GP also worked one day a week with dermatology patients at the local hospital to help improve their knowledge and skills. We were told this had helped to reduce the number of dermatology referrals made by the practice, and provided the other GPs with access to advice and support. The practice nurse we spoke with was studying for a qualification in practice management and had completed a non-medical prescribing course. They told us they received mentoring support from one of the GPs and that the practice provided its staff with appropriate support to undertake further training.

All the GPs were up-to-date with their annual continuing professional development requirements and had either had been revalidated or had a date 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 practise and remain on the performers list with NHS England).

Working with colleagues and other services

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

The practice held regular multi-disciplinary meetings to discuss patients with complex and end of life needs. These meetings were attended by the GPs, practice nursing staff and local healthcare professionals, such as health visitors and midwifes. The GP we spoke with told us they responded to patient demand from local sheltered housing schemes and care homes on the basis of need.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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 information about contact with any of its patients. There were arrangements in place which made sure this information was reviewed and actioned by the right clinician or team

Good

Are services effective?

(for example, treatment is effective)

member. The practice shared information about patients with complex care and treatment needs, or those who had an agreed Do Not Attempt Resuscitation order in place, with out-of-hours and urgent care providers. This helped to ensure patient data was shared in a secure and timely manner.

Systems were 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.) The GP we spoke with said the system worked well for their patients.

Consent to care and treatment

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The GP we spoke with demonstrated a clear understanding of consent and capacity issues. They were able to clearly explain when consent was necessary and how it would be obtained and recorded. The GP understood the practice's role in supporting patients who were subject to a MCA Deprivation of Liberty Safeguards (DOLs) Order. (The DOLs are part of the MCA 2005 and make sure that people living in care homes and hospitals do not have their freedom inappropriately restricted.)

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and what type of consent was required for specific interventions.

Health Promotion & Prevention

The practice did not carry out NHS health checks. The GP we spoke with told us the practice had made a decision not to provide this enhanced service for its patients. A notice informing patients of this decision was displayed in the waiting area.

The practice was good at identifying patients who needed additional support and was proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed that: 100% of eligible patients with dementia had received a range of specified tests six months before, or after, being placed on the practice's register. (This was 15 percentage points above the local CCG average and 19.8 points above the England average); 83.8% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (This was in line with the local CCG and England averages.) The practice had a system in place to identify patients who might be at risk of developing dementia. We were told this helped to ensure this group of patients received appropriate care and support, and clinicians were aware of their needs.

Nationally reported QOF data for 2013/14 showed the practice had recorded the smoking status of 97.9% of eligible patients aged over 15. The data also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. (This was 6.4 percentage points above the local CCG average and 6.3 points above the England average). However, the practice manager told us the practice no longer offered smoking cessation services, but was referring patients to local pharmacy services to access this support.

Nationally reported QOF data for 2013/14 showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. The data showed that the records of 87.5% of eligible women, aged between 25 and 65 years of age, contained evidence they had had a cervical screening test in the preceding five years. (This was 6.5 percentage points above the local CCG average and 5.6 points above the England average.)

The QOF data also showed 93.8% of eligible women, aged 54 or under, who were prescribed an oral or patch contraceptive method, had received appropriate contraceptive advice during the previous 12 months. (This was 1.2 percentage points above the local CCG average and 4.4 points above the England average.) Overall, the data showed that the practice's performance in providing contraceptive services was 2.5 percentage points above the local CCG and 5.6 above the England average. The practice also performed well in relation to the provision of maternity services. Their performance was in line with the local CCG and 0.9 above the England average.

Good

Are services effective?

(for example, treatment is effective)

We did not see any evidence during the inspection of how children and young people were treated by staff. However, neither the patients we spoke to, nor those who completed CQC comment cards, made us aware of any concerns about how staff looked after children and young people.

Good

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 for the practice, published in January 2015. The evidence from these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received. For example, of the patients who responded to the National GP Patient Survey: 84% said the last GP they saw, or spoke to, was good at giving them enough time. (This was slightly below the local CCG average of 89% and the national average of 86%); 91% said the last GP they saw, or spoke to, was good at listening to them. (This was slightly below the local CCG average of 92%, but above the national average of 88%); 87% said the last GP they saw, or spoke to, was good at treating them with care and concern. (This was in line with the local CCG average but above the national average of 82%.)

We received 44 completed CQC comment cards. The majority of the feedback received from patients was positive, with only a very small number raising concerns about the care and treatment they had received. We also spoke with four patients including a patient from the Patient Participation Group (PPG), on the day of our inspection. They told us the practice offered a good service and staff were caring and helpful. They confirmed they were treated with dignity and respect, and said staff were professional, compassionate and understanding. Of the patients who responded to the National GP Patient Survey, 91% said they found the receptionists helpful. (This was above both the local CCG average of 89% and the national average of 87%.)

During the inspection 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. The practice manager told us a private room was available should a patient indicate they wished to speak confidentially to a member of the reception team.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey for the practice, published in January 2015, showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, 71% of respondents said their GP involved them in decisions about their care. (This was below the local CCG average of 83% but above the national average of 84%;) 79% felt the GP was good at explaining treatment and results. (This was below the local CCG average of 86% and the national average of 82%.) None of the patients we spoke to on the day of our inspection raised concerns in this area.

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

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. However, we noted that neither the practice website nor their patient leaflet included information about how patients could access such support.

The practice's IT system alerted clinicians if a patient was also a carer, so this could be taken into consideration when they assessed their need for care and treatment. The practice manager told us clinical staff referred patients struggling with loss and bereavement to an appropriate support group, where this was appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. They had used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled staff to identify patients at risk of, for example, an unplanned admission into hospital. Action was being taken by the practice to prepare emergency care plans for this group of patients. We were told this had significantly impacted on staff's workload. However, the GP we spoke with told us the practice continued to make progress with this work and had kept the local Clinical Commissioning Group (CCG) aware of this.

The practice kept a register of these patients, and had written to each patient aged 75 years and over, explaining which GP would act as their named doctor. The practice nurse we spoke with told us that, in response to increasing numbers of older male patients with prostate cancer, a system had been put in place to ensure staff were able to deliver any follow-up care required.

The practice nursing team were mostly responsible for the delivery of chronic disease management. 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. (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.) A patient we spoke with said the practice managed their long-term condition well. They said they were satisfied with the care, treatment and advice they received to manage their condition. A system was in place for following up patients who failed to attend for a planned review.

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. Nationally reported Quality Outcomes Framework (QOF) data for 2013/14 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. The staff we spoke with told us these meetings included relevant healthcare professionals involved in supporting these patients, such as community nurses and health visitors. The overall QOF score for the provision of palliative care was 5.9 percentage points above the local CCG average and 3.3 points above the England average.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by a midwife. Nationally reported 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's performance for carrying out child health surveillance was in line with local CCG average and 1.1 percentage points above the England average. The GP we spoke with told us that local housing developments had had a significant impact on the services they provided to this population group, including the need to provide more childhood immunisations than they had previously provided.

The practice held a regular 'Well Baby' clinic. This provided mothers with access to various healthcare checks and any support they needed from the health visitor in attendance. The practice offered a full range of immunisations for children. Where nationally reported data enabled a comparison to be made, the percentage of eligible children who received the recommended vaccinations at the practice, was higher than the average percentage within the local CCG area. The data we looked at before the inspection had not identified the practice as being outlier and no level of risk had been attached the delivery of childhood immunisations.

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. They provided an extended hours service until 8:30pm one evening 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. Patients received recommended treatments for commonly found health conditions. For example, nationally reported data indicated that 93.5% of patients aged 16 years or over (but who were not yet 75) who had hypertension, had had an annual assessment of their physical activity, using a standardised tool, during the previous 12 months. (This was 10.5 percentage points above the local CCG average and 14.9 points above the England average.)

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had taken steps to identify patients with mental health needs and had made arrangements to meet their needs. Patients with mental health needs were able to access in-practice counselling and support from the community mental health team where this was appropriate. The practice maintained a register of all patients diagnosed with the mental health conditions specifically covered by the QOF. Maintaining such a register helps practices to offer proactive care, treatment and advice to this vulnerable group of patients. For example, nationally reported QOF data for 2013/14 showed that 96.2% of eligible patients with these conditions had a documented, comprehensive care plan in place, which had been agreed with their carers where appropriate. (This was 6.3 percentage points above the local CCG average and 10.3 points above the England average.) Overall, the practice had achieved all of the QOF points available to them for providing services to patients with mental health needs. (This was 3.6 percentage points above the local CCG average and 9.6 points above the England average.)

The practice had identified those patients who were cared for and those who were carers. This was flagged on the practice's IT system to alert clinicians so it could be taken into account when assessing these patients' care and treatment needs. We saw that carer information was easily accessible within the practice reception area.

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information for patients who had palliative care or complex health needs. This enabled them to access important information about these patients when necessary and provide appropriate care.

Tackle inequity and promote equality

The practice had made arrangements which demonstrated their commitment to tackling inequity and promoting equality. The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. The practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities, complex health conditions, and those receiving palliative care. Nationally reported QOF data for 2013/14 showed that the practice had achieved all of the points available to them for providing services to patients with learning disabilities. (This was 10.1 percentage points above the local CCG average and 15.9 points above the England average.)

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The premises had been purpose built to meet the needs of patients with disabilities. For example, all of the consultation and treatment rooms, and the reception area, were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. The main doors into the practice were automatic. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a small number of patients whose first language was not English. Staff had access to a telephone translation service and interpreters should they need this.

Access to the service

Appointments were available from 08:00am to 6:30pm four days a week, and extended hours from 08:00am to 8:30pm one evening a week. Providing extended hours makes it easier for working age patients and families to obtain an appointment.

Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice website. Patients were offered routine appointments which they could book several months in advance. The practice website advised patients who felt they needed an early appointment that they would be offered one within two working days. Patients were also told that the wait might be longer if a patient wanted an appointment with a preferred doctor. The practice manager told us that patients requesting a same-day urgent appointment would always be contacted by telephone to determine the most appropriate response to their needs.

Of the patients who participated in the National GP Patient Survey, published in January 2015: 84% said they were satisfied with the practice's opening hours. (This was above both the local CCG (82%) average and the national (76%) average); 61% of those who had a preferred GP, usually got to see or speak to that GP. (This was above both the local CCG (59%) and the national (60%) average); 90% said they found it 'easy' to get through on the telephone to someone at the practice. (This was above the local CCG (79%) average and the national (71%) average); 81% said they

Good

Are services responsive to people's needs?

(for example, to feedback?)

usually waited 15 minutes or less after their appointment time to be seen. (This was above both the local CCG (70%) average and the national (65%) average.) We spoke with a member of the PPG who confirmed they were satisfied with the practice's appointment system. No concerns were raised by patients we spoke with on the day of our visit or those who had completed CQC comment cards.

The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and 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 clear information about how to complain, and included timescales within which concerns would be addressed. The website informed patients that an apology would be offered where they had not got things right. Information about how to complain was also on display within the practice reception area. The Practice Participation Group (PPG) member we spoke with said they had never had to make a complaint but would feel comfortable in doing so. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously. The practice carried out an annual review of the complaints they had received to ensure they had been appropriately addressed.

The practice had received five complaints since April 2014. From the information supplied by the practice we were able to confirm they responded appropriately to the concerns raised. All of the complaints received involved communication issues. One of these involved a patient's dissatisfaction with the arrangements for prescribing a product they took on a regular basis. We saw the complaint had been taken seriously, investigated and written feedback was given to the complainant. The records we looked at showed the practice offered an apology when they had not got things right.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Information about this was available on their website. The practice had developed an action plan which covered the areas where they wanted to make improvements. This included, for example, how the practice could address 'Did Not Attend' (DNA) appointment rates. We saw this involved publishing monthly DNA rates. The practice had a mission statement which set out its aims and objectives. The practice manager told us staff had been involved in the preparation of the mission statement. Most of the staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. There was evidence the practice had carefully considered the future demands likely to be placed on the service, such as the increase in the number of registered patients and planned staff retirements.

Governance Arrangements

Arrangements for assessing, monitoring and addressing risks were in place. The practice had prepared a business continuity plan to help ensure all staff were clear about their role in responding to an emergency. There were effective arrangements for dealing with individual patient risks. For example, the practice had used a recognised risk assessment tool to profile patients according to the risks associated with their conditions.

There was evidence of effective engagement between the GPs and other members of the practice team. A member of the reception team told us full staff meeting took place regularly and that the GPs welcomed feedback and suggestions from staff. We confirmed that weekly partner and monthly clinical meetings also took place.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured that significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected.

The practice had made arrangements to monitor their 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.) Medicine audits were carried out in partnership with a pharmacy adviser, which helped to ensure the GPs prescribed effectively and safely. Regular checks of the practice disease registers were carried out to make sure patients received recommended levels of care and treatment. The CCG visited regularly to assess the practice's performance in a range of areas. This included comparing how the practice performed against other practices in the local CCG.

The practice had a range of policies and procedures in place governing its activities and the services it provided to patients. Staff were able to access these in a variety of ways. The practice had recently updated their information governance toolkit to help ensure information was handled sensitively and in a secure and confidential manner. Certificates confirming this were available on file.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. They said they were an important part of the team, were well supported and would feel comfortable raising concerns with the practice management team or the GP partners.

Regular practice and multi-disciplinary team (MDT) meetings took place where operational issues and patients' needs were discussed. For example, weekly partners' meetings were held to discuss clinical issues and any matters affecting the day-to-day operation of the practice. Separate meetings were also held to review complaints and significant events. The GP we spoke with told us that these were also discussed at the time they occurred using the more regular practice meetings. We saw minutes had been kept of the meetings held. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings.

Are services well-led?

Good

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

Systems were in place to identify and manage risks. 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 told that, where concerns were identified which might have a negative impact on patients, any risks were discussed within the partners and an agreement reached about how they would be managed.

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

The practice had made arrangements to seek and act on feedback from patients and staff. For example, patients were invited to complete a Friends and Family Survey (FFS) following a visit to the practice. The practice website included information about the FFS and how to access it.

The practice had an active patient participation group (PPG). Information about how to join the group was available in the patient reception area. The PPG met quarterly and was responsible for carrying out an annual patient survey and for interpreting the results with the support of practice staff. The PPG member we spoke with said the group was also responsible for monitoring whether previously agreed objectives had been implemented. The PPG member told us the practice welcomed the involvement of the PPG and responded positively to its comments.

The practice website provided patients with access to the results of the 2013/14 in-patient survey. The PPG had devised an action plan for 2014/15 which covered areas in which patients felt improvements could be made. For example, patients felt it was sometimes difficult to access the on-line system for making appointments and ordering repeat prescriptions. We saw that the practice manager had agreed to address this with the system provider.

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. The staff we spoke to felt valued and said they felt they were key members of the practice team.

Management lead through learning & improvement

The practice provided staff with opportunities to continuously learn and develop. A practice nurse told us they had opportunities for continuous learning to enable them to retain their professional registration, and to develop the skills and competencies required for chronic disease management. 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 also demonstrated its strong commitment to learning by providing opportunities for its senior GP partner to act as a GP tutor. Reviews of significant events had also taken place and the outcomes had been shared with staff via meetings. This helped to ensure the practice improved outcomes for patients through continuous learning.