Broadway Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 carried out a comprehensive announced inspection at Broadway Medical Centre on 02 December 2014. 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 at providing services for the six key population groups we looked at during the inspection.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- Risks to patients were assessed and well managed;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and were involved in decisions about their care and treatment;
- Information about the services provided by the practice was available and easy to understand, as was information about how to raise a complaint;
- Patients said they found it easy to make an appointment and urgent, same-day access was also 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 clearer processes for carrying out Disclosure and Barring Service (DBS) checks are in place;
- Review the current arrangements for monitoring the temperatures of refrigerators storing vaccines and other medicines requiring cold storage.

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.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management, although staff were not consistently checking the temperatures of the refrigerators used to store vaccines. Overall, staff recruitment practices were safe. However, the practice needed clearer processes for carrying out Disclosure and Barring Service (DBS) checks. There were enough staff to keep patients safe and meet their needs. Good infection control arrangements were in place and the practice was clean and hygienic.

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area. 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). Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinical staff with their continuing professional development. Although the appraisals for non-clinical staff were overdue, the practice had made arrangements to address this shortfall. There were effective 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.

Nationally reported data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local CCG area. The majority of patients said they were treated well and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to information and

Summary of findings

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local CCG area. Services had been planned so they met the needs of the key population groups receiving services from the practice. Patient feedback about the practice was generally good. The practice had taken steps to reduce emergency admissions to hospitals 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 procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them.

Are services well-led?

Good

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

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. An effective governance framework was in place which suited the size of the practice. Staff were clear about their roles and understood what they were accountable for. The practice had a range of policies and procedures covering its activities. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older patients.

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

People with long term conditions

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with common long-term conditions. The practice had taken steps to reduce unplanned hospital admissions to hospital by improving services for patients with complex healthcare conditions. All patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. 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.

Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, and the provision of contraception and maternity services. Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The needs of this group of patients had been identified and steps had been taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. Patients could order repeat prescriptions and book appointments on-line. Extended hours appointments were available until 7:45pm one evening a week. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as smoking cessation, travel vaccinations 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.

The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register identifying which patients fell into this group. They used this information to ensure they received an annual healthcare review and other relevant checks and tests. Staff worked with relevant community healthcare professionals to help meet the needs of vulnerable patients registered with the practice. 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 were aware of their responsibilities regarding information sharing, recording safeguarding concerns and contacting relevant agencies during normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. They practice kept a register of these patients 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. The practice regularly worked with other community healthcare professionals to help ensure patients' needs were identified, assessed and monitored.

Summary of findings

What people who use the service say

During the inspection we spoke with five patients and reviewed 40 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 2014 National GP Patient Survey, and a survey carried out by the practice in 2014, indicated most patients had a good level of satisfaction with the care and treatment provided. For example, of the patients who responded to the 2014 National Patient Survey:

- 93% said the last GP they saw, or spoke to, was good at listening to them. (The practice's own survey found 98% of patients rated this area as either 'very good' or 'good');
- 91% said the last GP they saw or spoke to was good at giving them enough time. (The practice's own survey found 94% of patients rated this area as either 'very good' or 'good');
- 87% said the last GP they saw or spoke to was good at treating them with care and concern. (The practice's own survey found 98% of patients rated this area as either 'very good' or 'good');
- 88% said the last GP they saw or spoke to was good at explaining tests and treatments. (The practice's own survey found 94% of patients rated this area as either 'very good' or 'good');
- 95% said they had confidence and trust in the last GP they saw or spoke to.

All of the National GP Patient Survey results were above the average for the local Clinical Commissioning Group (CCG) area. These results were based on 107 surveys that were returned out of a total of 386 sent out. The response rate was 28%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure clearer processes for carrying out Disclosure and Barring Service (DBS) checks are in place;
- Review the current arrangements for monitoring the temperatures of refrigerators storing vaccines and other medicines requiring cold storage.

Broadway Medical 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 and a GP.

Background to Broadway Medical Centre

Broadway Medical Centre is a busy city practice providing care and treatment to 2586 patients of all ages, based on a Personal Medical Services (PMS) contract agreement for general practice. The practice is part of NHS Newcastle West Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Newcastle upon Tyne West area. It serves an area that has lower levels of deprivation for children, and higher levels of deprivation affecting people in the over 65 age group, than the England averages. The practice's population includes fewer patients aged under 18 years, and more patients aged over 65 years of age, than other practices in the local CCG area.

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

Broadway Medical Centre, 164 Great North Road, Gosforth, Newcastle upon Tyne. NE3 5P.

The practice occupies an adapted semi-detached house. The premises are fully accessible to patients with mobility needs. Broadway Medical Centre provides a range of services and clinic appointments, including for example, for those patients with asthma, diabetes and heart failure. The practice consists of two GP partners (one male and one female), a practice manager, a business manager, three nurses and reception staff.

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

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

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008: to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

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 02 December 2014. During this we spoke with a range of staff including: the full time GP partner; the practice manager; the business manager (provided support to the practice but was also employed at another local practice); a practice nurse and a member of the reception team. We spoke with five patients from the Patient Participation Group (PPG) who visited the practice on the day of our inspection. We observed how staff communicated with patients who visited, or telephoned the practice, on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed forty Care Quality Commission (CQC) comment cards that had been completed by patients using the practice.

Are services safe?

Our findings

Safe Track Record

When we first registered this practice, in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about 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, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with raised no concerns about safety at the practice.

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

Learning and improvement from safety incidents

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

Four significant events had taken place during the previous 12 months. The sample of significant event records we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent reoccurrences. For example, a report had been completed regarding a significant event where a prescription for a short-term antibiotic did not reflect the guidance set out in a local guideline. The event had been discussed within the practice and at a practice multi-disciplinary team (MDT) meeting involving other healthcare professionals. We saw that guidance had been recorded about what action should be taken to prevent this from happening in the future. The practice had also offered apologies where they judged they could have done better.

All of the staff we spoke with were aware of the system in place for raising issues and concerns. The practice also reported relevant incidents to the local CCG, using the local safeguarding incident reporting system. This required them to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service.

Arrangements had been made which ensured national patient safety alerts were disseminated to the relevant staff within the practice. This enabled these staff to decide what action should be taken to ensure continuing patient safety, and mitigate risks by responding to safety alerts.

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. The two GP partners shared lead roles for safeguarding children and adults. Staff we spoke with said they knew the GP partners were the safeguarding leads.

Both GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Nurses at the practice had completed Level 2 which is more relevant to the work they carry out. This was confirmed by the staff we spoke with. The practice manager told us staff completed child protection and adult safeguarding training during practice 'time-out' sessions run by the local CCG. When we looked at practice training records we found it difficult to confirm that all staff had completed the relevant safeguarding training. The practice manager told us that following the inspection they would ensure the training records contained more detail about what training staff completed at the CCG 'time-out' sessions.

Are services safe?

A chaperone policy was in place and information about this was displayed in the reception area. All of the patients we spoke with said they knew they could access a chaperone if they needed one. All confirmed they would trust staff to provide this service and would feel comfortable using it.

Chaperone training had been undertaken by all clinical and non-clinical staff who carried out chaperone duties. However, non-clinical staff undertaking chaperone duties had not undergone a Disclosure and Barring Service (DBS) check. A documented risk assessment setting out why non-clinical staff carrying out chaperone duties had not been DBS checked was not in place. We raised this with the practice who confirmed they would take action to follow the Mythbuster guidance provided by the CQC. They also told us DBS checks would be completed for all non-clinical staff.

There was a system on the practice's electronic records to highlight vulnerable patients. 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). Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records. We were told clinicians actively engaged with local safeguarding agencies and professionals such as the local children's safeguarding board.

Arrangements were in place to follow up children who failed to attend appointments, to help ensure they did not miss important immunisations. A member of the nursing team told us a system was in place to follow up non-attendance, and that this worked well. Practice staff used their regular MDT meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information.

Medicines Management

Arrangements were in place to check the storage of medicines requiring cold storage. A member of the nursing team told us refrigerator temperatures were regularly checked to help ensure they were stored correctly. We looked at the record kept of the checks carried out and saw there were gaps. A member of the nursing team told us they had already identified this as a problem and said arrangements were being made to address the issue.

The practice had effective arrangements for monitoring the expiry dates of emergency medicines and medical gases, and the ordering of new supplies. We found all emergency medicines, including those for the treatment of anaphylaxis, were in date. We identified that the range of emergency drugs available was less than might normally be expected. Because of its close vicinity to a number of large hospitals and local pharmacies, the practice told us they did not need to keep a stock of controlled drugs.

Patients were able to order repeat prescriptions using a variety of ways. This included visiting the practice, or ordering by telephone, on-line and by post. The web site provided patients with helpful advice about ordering repeat prescriptions, including advising new patients they would have to been seen by one of the GPs before any repeat prescriptions could be authorised.

The practice made use of the Electronic Prescription System (EPS). This enables prescribers, such as GPs and nurses, to send prescriptions electronically to a dispenser (pharmacy) where this is the patient's preferred choice. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. A member of the reception team told us all repeat prescription requests were sent through to the GP partners for checking and authorisation. They said the system was safe and worked well.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. This was confirmed by the patients we spoke to who told us the practice was always clean. Cleaning schedules and notices reminding patients and staff of the importance of hand washing were on display in toilets and other areas of the practice. An infection control policy and procedures were in place and 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 been completed in November 2014 to help identify any shortfalls or areas of poor practice.

The senior GP partner acted as the infection control lead and provided guidance and advice to staff when needed. We were told they were supported in carrying out this role

by the practice nurses. We were told staff had completed infection control training. This was confirmed by a member of the nursing team. However, when we looked at practice training records we found it difficult to confirm that all staff had completed training in this area. The practice manager told us that following the inspection they would ensure the training records contained more detail about what training staff completed at the local CCG 'time-out' sessions.

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 laundered on a monthly basis.

Spillage kits were available to enable staff to deal safely with 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. These 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.

At the time of our visit, an up-to-date legionella (a bacterium that can grow in contaminated water and can be potentially fatal) risk assessment was not in place and appropriate checks were not being carried out. Shortly following the inspection, we were provided with evidence confirming appropriate checks had been carried out by an external contractor. The practice manager told us they would ensure the required checks were carried out regularly.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments, and for the sterilisation of those which could be used more than once.

Equipment was inspected and regularly serviced. We saw records confirming calibration testing of practice equipment had taken place during the last six months and all the portable electrical equipment had been tested within the last 12 months. Fire equipment checks were also carried out regularly and a fire drill had recently been undertaken. A fire risk assessment had been completed but it had not been reviewed within the last 12 months. The practice manager told us the risk assessment would be reviewed and, and if necessary, updated following the inspection.

Staffing & Recruitment

The practice had a set of recruitment policies and procedures. Although these provided clear guidance about the pre-employment checks that should be carried out, some of the information was out-of-date or referred to another practice that Broadway Medical Centre had developed links with.

Pre-employment checks had been undertaken to help make sure only suitable staff were employed. We looked at the records of a nurse clinician who had been appointed since the practice registered with the CQC. A written reference had been obtained from their previous employer, and employment history information had been obtained. The clinician had a NHS Smart card containing a recent identification photograph and we were told their identity had been verified under the NHS Employment Check Standards process. The practice had also obtained a copy of their driving licence as an extra identity check.

The GP partners had undergone a Disclosure and Barring Service (DBS) check as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate. We were told the most recently appointed nurse clinician had also undergone a DBS check which had been checked by an ex-GP partner. However, there was no documentary evidence confirming this. This person was available during the inspection and was able to confirm to us that a DBS check had been carried out at the time of their appointment. The practice manager agreed to ensure documentary evidence confirming this was available at the practice. We checked the General Medical and Nursing and Midwifery Councils records and confirmed all of the clinical staff working at Broadway Medical Centre were licensed to practice.

Are services safe?

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. For example, the practice had used a risk assessment screening tool to identify those patients at risk of an unplanned admission to hospital. Protocols were in place for high risk patients and the practice had provided relevant healthcare professionals with access to an emergency bypass number, to facilitate access to advice and information for urgent matters.

The practice completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and promote learning within the team.

The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. Practice staff monitored the safety of the building to ensure patients were not placed at risk. This included carrying out regular checks of the premises to make sure there were no hazards. We checked the building and found it to be safe and hazard free. None of the patients we spoke to raised any concerns about health and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We looked at a sample of records which showed staff had received training in cardio-pulmonary resuscitation (CPR). There was equipment available for use in emergencies including: oxygen, an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and an emergency medicines kit. The staff we spoke with knew the location of this equipment and weekly checks were undertaken by the nursing team to make sure it was in good working order and fit for purpose.

Emergency medicines were stored securely so that only relevant practice staff could access them. This included medicines for the treatment of a life-threatening allergic reaction, antibiotics, aspirin and a spray used to treat angina. Arrangements were in place to regularly check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date. Practice staff were aware of where the emergency medicines were kept.

The practice had a business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. The plan covered the actions to be taken to reduce and manage a range of potential risks. Risks identified included the loss of power and access to patients' medical records.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice 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 access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. We were told for example that the NICE guideline on obesity had been discussed at a practice multi-disciplinary team (MDT) meeting. The guideline had then been reviewed by the senior GP and action plans developed to ensure clinical staff knew how to apply them.

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. The practice made use of e-templates linked to relevant NICE guidelines to guide and record the outcomes of their consultations with patients. We were told these had been developed by another Clinical Commissioning Group (CCG) and were recognised as representing best practice.

Clinical responsibilities were shared between the two GP partners and the practice nursing team to help ensure each member of staff was clear about their roles and responsibilities. Clinical staff we spoke with were very open about asking for and providing colleagues with, advice and support. For example, a practice nurse told us they had identified an area in which improvements needed to be made and had shared this with the practice management team.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 99.9%) for all but one of the 20 clinical conditions covered. The practice had obtained 99.2% of the points available for the Diabetes Mellitus clinical condition. This was still above both the local CCG and England averages. (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 such as diabetes and implementing preventative measures. The results are published annually.)

The practice participated in the local CCG's practice engagement programme. Representatives of the CCG visited the practice every quarter to assess their performance and provide them with feedback about any improvements they needed to make. The practice said they found it helpful as it provided support to improve the way they delivered services. We looked at the last visit report produced by the CCG and saw the practice's current level of achievement had been judged as good with feedback given about areas that could be improved upon.

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. For example, the GP partners used a standardised dementia screening tool to help identify and treat patients with potential cognitive impairments.

Practice staff had the knowledge, skills and competence to respond to patients' needs. The practice was able to show us a training matrix which detailed what training staff had completed and when. We saw clinical nursing staff had access to training on, for example, smoking cessation, influenza and immunisations, and carrying out diabetic and asthma reviews. A practice nurse confirmed they had all of the training they currently needed to carry out their role. This included training in cervical screening and administering travel vaccinations. They told us they had also completed training updates in other areas such as infection control and cardio pulmonary resuscitation (CPR).

Interviews with the GP partners and a practice nurse demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making. Patients we spoke with said they felt well supported by the clinical team and were involved in making decisions and choices about their treatment. This was reflected in most of the comments made by patients who completed Care Quality Commission (CQC) comment cards.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the senior GP had a special interest in urology (study of diseases of the urinary tract) and was a trained surgeon. They also acted as the men's health lead. Other clinical and

Are services effective?

(for example, treatment is effective)

non-clinical staff had been given responsibilities for carrying out other designated roles, including for example, making sure emergency drugs were up-to-date and fit for use.

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

The practice had a rolling programme of clinical audits. We looked at a sample of the clinical audits that had been undertaken recently. These included repeat audit cycles where the practice was able to demonstrate the changes that had taken place since the initial audits had been carried out. For example, we saw that one of the GP partners had completed a clinical audit to test whether 141 patients registered with the practice who had type 2 diabetes, had achieved the blood pressure target recommended by NICE. The GP had then audited their original findings to see whether the practice had continued to offer the specified treatment to this group of diabetic patients, and concluded they had. We saw that the findings indicated that the number of patients who received this treatment was significantly higher than the national levels in both England and Wales.

A full clinical audit cycle had also been carried out to assess whether female patients with an uncomplicated urine infection had received appropriate antibiotic therapy. We saw that following this, a range of improvements had been made. These included ensuring a copy of local guidelines for managing this condition was kept in each consultation room and patient information leaflets were available in the waiting area. Other clinical audits carried out including testing the effectiveness of treatments for patients with chronic heart failure and hypertension.

The practice was proactive in the management, monitoring and improving of outcomes for patients. The practice used the information they collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. For example: 100% of patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of their test results; 100% of patients with a diagnosis of heart failure had had this confirmed by an echocardiogram (ECG) or by specialist assessment three months before, or 12 months after, being entering onto the practice's disease register. (ECG – equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.) We confirmed the practice had met all the QOF clinical indicators in relation to a range of clinical indicators such as epilepsy, asthma and chronic obstructive pulmonary disease (COPD.) (COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.) The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF clinical targets.

The practice also participated in the local CCG's practice engagement programme. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice's performance was good in terms of its achievement against prescribing indicators set by the local CCG.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The partnership consisted of two GP partners. The senior partner had completed a post-graduate diploma in Urology, and provided specialist urological advice for men's health at the practice and at a local hospital. Both GPs were up-to-date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). However, we were told that most other staff had not had an appraisal since January 2013. The practice manager told us steps were being taken to address this shortfall, and all outstanding staff appraisals had been pre-booked to take place in February 2015.

The practice nurse we spoke with told us they were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, they told us they had completed training in sexual health and wound care. The sample of training records we looked at confirmed this. The practice nurse confirmed

Are services effective?

(for example, treatment is effective)

they had completed a range of other relevant training in their previous role. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

We looked at the staff rota and identified there was always a GP on duty when the practice was open. We saw holiday cover was either provided by a known GP locum or the second partner increased their hours. We were able to confirm that a 'locum pack' (written guidance) was in place to assist with the induction of any GP covering at the practice.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team was able to maintain services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

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

The practice worked in collaboration with another larger local practice. We were told this was beneficial for both practices and helped to maximise benefits for patients. The business manager for the larger practice provided some business oversight of Broadway Medical Centre and its day-to-day activities. The larger practice provided staff cover at Broadway Medical Centre for one afternoon a week and in return for this, the senior GP partner covered a weekly session for them.

The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end of life care needs. These meetings were attended by practice nursing staff as well as other local healthcare professionals such as health visitors. Minutes were kept of each meeting and we were told patients' records were updated following these.

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. A member of the reception team told us all staff were fully trained on the system. This system enabled scanned paper communications, such as those from hospital, to be saved for future reference.

The practice used several systems to communicate with other providers. For example, there was an agreed process for sharing information with the local out-of-hours provider which ensured the practice received written information about contact with any of its patients. We were told any information received was firstly reviewed by one of the GP partners and then scanned onto patients' electronic medical records. A member of the administrative team said this process worked well.

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 using a CCG wide system. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the 2014 National GP Patient Survey, 82% said the GP they visited had been 'good' at involving them in decisions about their care. Of the patients who responded to the practice's own survey, 90.2% said their GP had been 'good' or 'very good' at involving them. A similar high level of satisfaction was noted in relation to the care and treatment provided by nurses working at the practice.

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The senior GP partner we spoke with demonstrated a clear understanding of consent and capacity issues and the Gillick competencies. (These

Are services effective?

(for example, treatment is effective)

help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Staff were able to clearly explain when consent was necessary and how it would be obtained and recorded.

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 it detailed what type of consent was required for specific interventions.

The practice kept a register of patients who had learning disabilities. We were told these patients, and, where appropriate, family members or carers, were actively involved in the assessment of their needs and that their views were recorded in their medical records.

Health Promotion & Prevention

It was practice policy to offer all new patients a health check with a practice nurse. New patients were able to download a registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, or send by post or hand into the reception team. Practice nurses carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems. The practice offered NHS Health Checks to all patients aged between 40 and 75 years of age. NHS Health Checks had been offered to 84 patients in 2013/14. (This NHS programme aims to keep patients healthier for longer.)

The practice was good at identifying patients who needed additional support and were pro-active in offering this. For example, there was a register of all patients with dementia. Nationally reported data for 2013/14 showed that: 100% of patients with dementia had received a range of specified tests six months before, or after being placed on the practice's register; 87.5% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (Both of these scores were above the local CCG average.) The practice had systems in place to identify patients who might be at risk of developing dementia which included placing a flag on their medical records to alert clinical staff to this.

Nationally reported data for 2013/14 showed the practice had recorded the smoking status of 92.9% of patients aged over 15. The figures also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy**.**

Nationally reported data for 2013/14 showed the practice had protocols that were in line with national guidance, covering such areas as the management of cervical screening. The practice also had a system in place for informing women of the results of cervical screening tests. The practice manager told us 81.4% of women aged between 24 and 64 had received a cervical screening test in the last five years.

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.

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 2014 National GP Patient Survey and the 2014 patient survey carried out by the practice. 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 Patient Survey: 91% said the last GP they saw, or spoke to, was good at giving them enough time; 93% said the last GP they saw, or spoke to, was good at listening to them; 87% said the last GP they saw, or spoke to, was good at treating them with care and concern. All of these scores were above the local Clinical Commissioning Group (CCG) average. Scores for nurses working at the practice were higher than the regional average in all of the areas referred to above. Patients who completed the practice's own survey rated its performance more highly, for example, 98.5% rated the practice as either 'very good' or 'good' in terms of being listened to and treated with care and concern.

We received 40 completed Care Quality Commission (CQC) comment cards. The feedback received from all patients was, with one exception, positive. We also spoke with five patients on the day of our inspection. Patients told us the practice offered a really good service and staff were understanding and very professional. They confirmed staff treated them with dignity and respect, provided them with a good service.

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

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey 2014 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, 89% of respondents said their GP involved them in decisions about their care; 91% felt the GP was good at explaining treatment and results. Both of these responses were above the local CCG average. Patients who completed the practice's own survey rated its performance more highly, for example, 94% rated the practice as either 'very good' or 'good' at explaining tests and treatments. The majority of patients who completed CQC comment cards did not raise any concerns in this area and neither did any of the patients we spoke to on the day of our inspection.

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

Patients we spoke with were positive about the emotional support provided by the practice. The CQC comment cards we received were also consistent with this feedback. For example, the majority of patients commented the GPs were caring and supportive. None of the patients we spoke with raised any concerns about the support they received to cope emotionally with their care and treatment.

We observed patients in the reception area being treated with kindness and compassion by staff. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice had recently set up a carer's register to help them identify and make sure they were receiving the professional support they needed. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

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. The practice 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. 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 nursing team were responsible for the delivery of chronic disease management. Nursing staff told us they had access to a range of leaflets which they would give to patients to help them understand how to manage their condition. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD), an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team. Staff told us patients were recalled for reviews during their birthday month, during which screening tests would be completed and lifestyle advice and guidance given. The Patient Participation Group (PPG) members we spoke to said the recall system worked well and they felt they received good advice from the nursing team. Of the patients who participated in the 2014 National GP Patient survey: 91% said the last nurse they saw was good at explaining tests and treatment; 99% said they had confidence and trust in the last nurse they saw or spoke to. Both of these scores were above the local Clinical Commissioning Group (CCG) average.

The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. This helped to ensure staff were aware of which patients required extra support, care and treatment. Nationally reported 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. We were also told regular meetings took place involving healthcare professionals involved in supporting patients with palliative support needs. The scores for both of these were in line with the local CCG average, but above that for the England average.

The practice had identified the needs of babies, children and younger patients, and put plans in place to meet them. Nationally reported data for 2013/14 showed, for example, that: child development checks were offered at intervals consistent with national guidelines; 98.3% of women, aged 54 or under, who were prescribed an oral or patch contraceptive method, had received advice about long-acting reversible methods of contraceptive during the previous 12 months; antenatal care and screening were offered in line with current local guidelines. All of these achievements were above both the local CCG and the England averages. The practice offered a full range of immunisations for children, as well as travel and flu vaccinations. Nationally reported data indicated the practice had mostly performed better than other practices in the local CCG with regards to 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 7:45pm one evening a week, to facilitate better access to appointments for working patients. The practice website provided the working age patient population with information about how to book appointments and order repeat prescriptions, including how to do this on-line. The practice told us they had good uptake rates for NHS health checks and cervical smears with 488 out of 599 eligible patients agreeing to take the test. Nationally reported data indicated that 90.8% of patients of working age aged 40 years or over had had their blood pressure checked in the preceding five years. This achievement was above the local CCG and England averages.

Practice staff worked collaboratively with other professionals and agencies, and where appropriate, 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 healthcare needs. This enabled them to access important information about these patients when necessary and provide appropriate care. The local out-of-hours service, Northern Doctors, provided the practice with feedback on any patient they had seen. A process was in place to make sure this feedback was seen by one of the GP partners.

Are services responsive to people's needs?

(for example, to feedback?)

Advice on the criteria for requesting a home visit was available on the practice website. Clinical staff responded to requests for home visits by carrying out a telephone assessment. This helped them to decide whether a home visit was required, or whether a patient's needs might be more effectively met by accessing another type of service, such as the community nursing service.

Tackle inequity and promote equality

The majority of patients did not fall into any of the marginalised groups that could be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. We were told the practice took whatever action it could to meet the needs of patients who fell within this population group. For example, the practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities and those with complex health conditions.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The practice premises had been adapted to meet the needs of patients with disabilities. For example, clinical and consultation rooms, and the reception area, were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. Doors providing access to the practice had been automated to improve access. 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. Practice staff had access to a telephone translation service and interpreters should these be required. A member of the reception team said staff knew how to access these services if they needed to do so. We were told both of the GP partners were bi-lingual which had proved useful in helping the practice's Asian patients to access the medical care and treatment they needed.

Access to the service

Appointments were available from 08:00am to 6:00pm three days a week. On a Thursday the practice opened between 08:00am and 1:00pm. Extended hours were provided on a Monday with the practice opening between 08:00am and 7:45pm. Providing extended hours makes it easier for working age patients and families to obtain a convenient appointment.

Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site. The business manager told us every effort was made to provide patients with access to a GP or nurse appointment within 48 hours. Patients were offered routine appointments which they could book in advance. We were also told that patients requesting a same-day appointment would receive a telephone call from one of the GPs to assess whether an urgent appointment or home visit should be offered, or advice given. Patients were reminded of any booked appointments via a text reminder service. The practice website stated that it was the practice's aim to '…offer better use of healthcare resources by directing patients to appropriate services at the right time.'

Of the patients who participated in the 2014 National GP Patient Survey: 65% said they were satisfied with the practice's opening hours; 71% of those who had a preferred GP, said they usually got to see or speak to that GP; 92% said they found it 'easy' to get through on the telephone to someone at the practice; 85% said they usually waited 15 minutes or less after their appointment time to be seen, and 85% said that they didn't normally have to wait too long to be seen. All of these scores were above the regional CCG average. The practice received similar feedback when it carried out its own practice survey in 2014. For example, of the patients who responded to the survey: 84% said they were 'very satisfied' or 'fairly satisfied' with practice opening hours; 87% said they were usually seen on time, or waited between five to 15 minutes. We spoke with five members of the Patient Participation Group (PPG) and all confirmed they were satisfied with the practice's appointment system.

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. PPG members told us they had no concerns about this aspect of the practice's performance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice complaints policy and

Are services responsive to people's needs?

(for example, to feedback?)

procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all 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 available within the practice reception area. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously. The PPG members we spoke with said they had never had to make a complaint but would feel comfortable in doing so.

The practice had received three complaints during the previous 12 months. Two of these complaints had been resolved, and one was still in the process of being investigated. From the information supplied by the practice we were able to confirm they responded appropriately to concerns raised and apologised when they did not do as well as they should have done. We saw the clinicians involved had reviewed what had happened and what could be learnt to prevent a reoccurrence.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was clearly outlined in their 'practice appraisal' which they presented to us as part of the inspection. According to the 'practice appraisal', staff actively worked with the local Clinical Commissioning Group's (CCG) to deliver the '…top quality care that our commissioners want.' As part of this commitment, we were told the senior partner acted as a lead GP in the federation of which the practice was a part. (A federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local community.) The senior partner was also the GP Planned Care lead for the local CCG and helped to run a local GP education group. We were told the senior partner took on these roles to help the practice develop its vision and strategy, and deliver evidenced based care and treatment.

We were told an annual staff meeting took place to review any changes that needed to be made to take account of contractual changes in the GP contract. This meeting was also used to reaffirm what the practice did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes.

Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. A clinical member of staff told us the senior GP provided strong leadership and was very committed to the delivery of good quality care to patients. Although only a small practice, the senior GP partner had arranged for a business manager from another local practice to provide strategic support and financial and business advice to help them grow, develop and provide safe and effective patient care.

Governance Arrangements

The practice had a range of policies and procedures in place concerning its activities and the services it provided to patients. Staff were able to access these via the practice intranet or paper based files. The practice told us they were working towards putting arrangements in place to make sure practice policies and procedures were reviewed on a more regular basis.

Nationally reported Quality Outcomes Framework (QOF) data for 2013/14 confirmed the practice participated in an external peer review with other practices in the same CCG group, 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.) The practice was involved in the local CCG's practice engagement programme. This provided it with data about how well it performed in priority areas when compared to other local practices. The CCG had provided feedback that the practice's current achievement for the last quarter reviewed was good. The practice had also carried out a range of clinical audits aimed at improving the quality of care and treatment provided to patients.

Nationally reported data taken from the QOF for 2013/14 showed the practice had achieved an overall score of 99.9% of the maximum points available, for delivering care in line with the QOF clinical indicators. This achievement was above both the local CCG and the England averages. This confirmed the practice had delivered care and treatment in line with expected national standards. QOF performance data was regularly monitored by the practice management team and fedback to clinicians so that any corrective action required could be taken. This helped to ensure all staff were aware of how the practice was performing and to reach consensus about actions that needed to be taken to address any shortfalls.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. We were able to talk with the senior GP partner, a member of the nursing staff as well as the practice and business managers. All of them demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. The staff we spoke to were clear about their own roles and responsibilities. They all told us they felt respected, were well supported and would feel comfortable raising concerns with the practice management team.

Are services well-led?

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

There were systems and processes in place which facilitated the extraction of information to enable effective judgements to be made about the performance of the practice and where improvements needed to be made. For example, we found IT support was very effective. Practice management staff used a local risk assessment tool to carry out searches of patient information enabling them to generate data about which patients required what care, and how and when this should be provided. The practice IT system provided clinicians with access to a range of e-referral forms and chronic disease templates. These helped to ensure patients received prompt care because the right information about their needs had been collected during consultations.

Regular practice and multi-disciplinary team (MDT) meetings took place where operational issues and patients' needs were discussed. Staff used these to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated and outcomes for patients. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings.

Systems were in place to identify and manage risks. For example, the practice had a comprehensive 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 team and 'mitigating action was agreed and put in place.' However, we were also told staff sometimes failed to document the outcome of some of the risk assessments they carried out. This was recognised as a weakness which we were told would be addressed.

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. The practice had an active patient participation group (PPG). Information had been placed on the practice website encouraging patients to join the group, either virtually or in person. Although the PPG contained representatives from some of the key population groups, the group felt more could be done to encourage representation from younger patients or patients whose first language was not English. The PPG met regularly and representatives from the practice always attended to support the group. We spoke with five members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised. We saw the PPG had an agreed action plan for 2014/15.

Patients were provided with opportunities to comment on the services provided by the practice. The practice had carried out its own patient feedback survey in 2014. The survey covered areas such as patients' satisfaction with the appointments system, how patients were received at the practice, and the performance of their doctor or nurse. The outcome of the survey had been discussed at patient participation meetings (PPG) to identify what improvements could be made to address the feedback received. Information about the outcome of the survey had been placed on the practice website so this could be accessed by patients and other interested parties. The staff we spoke to felt valued and said they felt they were an important part of the practice team. Nursing and reception staff said the practice team worked well together in a positive manner to deliver good patient care.

This was a small practice with a small team which made it easier for information about the practice and its patients to be shared informally on a day-to-day basis. In addition to this, the practice management team gathered feedback from staff through staff meetings and appraisals. However, the business manager acknowledged they could be more effective at gathering staff feedback by ensuring that staff appraisals took place every 12 months. The staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used staff meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved in the process of improving outcomes for both staff and patients.

Management lead through learning & improvement

A range of systems were in place to monitor and improve the quality of the service. For example, we saw that the outpatient referral rates for both GP partners were closely monitored to detect any unwanted or unexplained trends. Arrangements had been made which helped ensure the practice was able to submit timely and accurate information to external bodies monitoring the performance

Are services well-led?

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

of the service. The practice management team regularly reviewed performance information to help ensure they were meeting QOF targets and providing good patient care and outcomes.

The practice provided staff with opportunities to continuously learn and develop. Practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. The practice demonstrated its strong commitment to learning by providing opportunities for medical students to complete training placements at the practice. Reviews of significant events had taken place and the outcomes had been shared with staff at staff meetings. This helped to ensure the practice improved outcomes for patients through continuous learning.