Bridge Surgery

Quality Report

St Peters Street
Stapenhill
Burton On Trent
Staffordshire
DE15 9AW
Tel: 01283 563451
Website: www.bridgesurgery.net

Date of inspection visit: 16 October 2014
Date of publication: 08/05/2015

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

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 3
The six population groups and what we found 5
What people who use the service say 8
Areas for improvement 8
Outstanding practice 8

Detailed findings from this inspection

Our inspection team 9
Background to Bridge Surgery 9
Why we carried out this inspection 9
How we carried out this inspection 9
Detailed findings 11

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 16 October 2014 as part of our new comprehensive inspection programme. We have rated this practice as good.

We found the practice to be good in the safe, effective, caring, responsive and well-led domains. The practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- There were systems in place to protect adults and children who used the service from the risks of harm.
- Staff were proactive in promoting good health and encouraging patients to be involved in and responsible for their treatment and wellbeing.
- Patients told us that the staff were compassionate, caring and respectful towards them.
- The practice listened to and acted on suggestions for improvement made by its patients, patient participation group (PPG) and staff.

We saw several areas of outstanding practice including:

- Significant events were discussed with the practices' patient participation group (PPG) and relevant professionals outside the practice so that all necessary improvements could be made and ideas to prevent re-occurrence shared.

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

In addition the provider should:

- Ensure that all staff are up to date with training related health and safety. This should include fire safety, infection control and equality and diversity.

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. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Patients who used the service told us that they felt safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Significant events were not only discussed with staff working for the practice but also with PPG group members and relevant professionals outside the practice so that ideas for improvement are shared. Information about safety was highly valued and used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both NICE and other locally agreed guidance. We saw evidence that patients' needs were assessed and care was planned and delivered in line with current legislation. We saw data that showed that the practice was performing at or above average when compared with other practices in the CCG area. We saw that the practice was proactive in addressing areas of under performance. The employment of a pharmacist has influenced prescribing and medicine management at the practice which has improved practice and outcomes for patients based on research and guidance. Staff had received training appropriate to their roles and any further training needs have been identified and planned for. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care was positive. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and

Summary of findings

treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and were aware of the importance of maintaining confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from patient participation group (PPG), patients and staff. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us that the practice continuously reviewed the appointment system to ensure that it was easily accessible for them. Patients told us that they could get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. There was evidence that the practice had a culture of learning, development and improvement. The practice had a clear vision and strategy to improve the services they provided. Staff told us that the practice had an open and supportive leadership and were clear about the vision and their responsibilities in relation to this.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients over the age of 75 had a named GP responsible for their care. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

The practice was responsive to the needs of older people. The GPs and nurses offered home visits and rapid access appointments for those with enhanced needs. Older people that we spoke with told us that they had care reviews and received visits at home when needed. Patient care reviews involved their identified carer or a family member if appropriate. Unplanned hospital admissions were reviewed and actions taken when necessary.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. The practice had arrangements in place to ensure that all patients with long term conditions such as asthma and diabetes had a named GP and a structured annual review to check that their health and medication needs were being met. Longer appointments and home visits were available when needed. For people with complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided a safe environment for mothers, babies, children and young people to be cared for. The practice worked well with health visitors who had offices in the building and a local midwifery service to offer a full health surveillance programme for children under the age of five years. The practice held weekly childhood vaccination clinics for babies and children. Child flu vaccinations were also provided. Immunisation rates were high for all standard childhood immunisations. Parents were able to access a GP urgently for serious childhood illnesses.

The practice offered or sign posted patients to appropriate agencies for sexual health education and contraception advice. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who missed appointments. Patients told

us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflected the needs of this age group. For example, there was a cervical screening programme in place for women aged 25 years and above. The programme ensured that there was a robust system for following up test results. Health promotion information such as well person checks was also provided online.

The practice opened from 8am and offered their last appointment at 6:00pm each evening during the week. This helped to provide some easier access for patients who were at work during the day.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There were no barriers to patients accessing services at the practice. The practice held a register of patients including those with a learning disability and care plans had been developed with the patient and their carer to support their individual needs. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Patients were encouraged to participate in health promotion activities, such as weight management and smoking cessation. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice who had mental health support and care needs. Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They worked closely with the local mental health team to identify patients' needs and provide appropriate counselling and support. The practice was aware of the complex needs of people living with dementia. To support their care needs advance care planning was carried out.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection; these patients were willing to share their experiences with the expert by experience who accompanied us on our inspection. We spoke with and received comments from patients who had been with the practice for many years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were respected, well cared for and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by all staff.

Some patients said that they had experienced the problems associated with a busy practice. This included for example getting through to reception on the telephone and the time they waited to be seen at their appointments. However patients were happy that they were able to see the doctor they wanted to and were happy with their appointment and consultation. Patients told us that they found staff polite and approachable and had not had cause to make a complaint with the way they were treated. Patients felt that that if they had to make a complaint that they would be listened to and their complaint dealt with promptly. Overall patients said that they found the practice helpful and friendly. There were two comment cards completed before our inspection. Both comment cards complimented the service, staff and GPs.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 GP national patient survey showed that over 92% of practice respondents said the GP involved them in care decisions. This result was above the CCG area average. The practice had completed two surveys. One survey showed that a total of 97% of patients would be extremely likely or likely to recommend the practice to family and friends. The second survey was carried out by an external organisation which allowed the results to be compared nationally. Results from this showed that overall patients were happy with the service they received. For example 85% of respondents were happy with the explanations they received about their care and 88% said that they were shown respect. The key issues for some patients were access, choice of GP and waiting times for appointments. The practice was seen to be taking steps to address these issues.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff are up to date with training related to health and safety. This should include fire safety, infection control and equality and diversity.

Outstanding practice

- Significant events were discussed with the practices' patient participation group (PPG) and relevant professionals outside the practice so that all necessary improvements could be made and ideas to prevent re-occurrence shared.

Bridge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager and an expert by experience (a person who has experience of using this particular type of service, or caring for someone who has).

Background to Bridge Surgery

Bridge Surgery provides primary medical services to patients living in Burton On Trent, Staffordshire and is located in the area of Stapenhill of Burton On Trent. The practice is a converted two storey Victorian school building. The ground floor consists of nine consulting rooms, a treatment room, a waiting room and reception desk with a lower counter access and separate office area. There is level access at the rear of the building and disabled toilet facilities. On the first floor there is a kitchen and staff room, a meeting room/library and several offices for administrative staff, district nurses and health visitors.

At the time of our inspection there were seven GP partners (5.5 WTE) providing a total of 50 clinical sessions per week. Other staff at the practice include two GP trainees, three practice nurses, two healthcare assistants, a clinical housekeeper, a pharmacist, a practice manager, two administrative staff, four secretaries and ten receptionists to provide care and treatment for approximately 9,900 patients. There are five female, four male doctors and three female nurses at the practice to provide patients with a choice of who to see.

Bridge Surgery is an approved GP training practice for Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine).

The practice is not a dispensing practice; their patients obtain their prescribed medicines from their local chemists.

The practice treats patients of all ages and provides a range of medical services. Bridge Surgery has a large percentage of its practice population, 65% in the working age group.

The practice does not provide an out of hours service to their own patients. They have alternative arrangements with Staffordshire Doctors Urgent Care Ltd. for their patients to be seen when the practice is closed.

The practice has a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. A GMS contract is a contract between General Practices and NHS England for delivering primary care services to local communities.

Why we carried out this inspection

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

This practice had not been inspected before under our new inspection process and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, East Staffordshire CCG and the local Healthwatch to tell us what they knew about Bridge Surgery and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 16 October 2014. During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, healthcare assistants and reception and administration staff. We spoke with eleven patients and members of the patient participation group (PPG) who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

We saw that the practice was able to demonstrate a track record for maintaining patient safety. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example we saw details of an incident involving prescribing an antibiotic. Information available showed that that the incident was openly reported, investigated and an action plan put in place to prevent this occurring again.

GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We reviewed safety records and incident reports and minutes of meetings where incidents that had occurred over the last 12 months were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw that a central record was kept of significant events that had occurred during the last 12 months and these were made available to us. We saw that significant events were included on the practice governance meeting agenda. These meetings were held every two months to review actions from past significant events and complaints. If the incidents were urgent they were discussed and reviewed at a weekly practice meeting.

We saw incident forms were easily accessible to staff. Once completed these were sent to the practice manager who showed us the system used to oversee these were managed and monitored. A central log was maintained of all incidents and significant events. Records showed that 25 incidents had been reviewed over the last 12 months. We tracked four incidents and saw records were completed in a comprehensive and timely manner. Information we read showed that the relevant member of staff was responsible for presenting the significant incident at the governance meetings. For example if the incident was related to a medication error the practice pharmacist presented the case. A description of the event, what could have been done differently and what action should be taken to minimise the risk of the incident re-occurring and learning outcomes were discussed. Minutes showed details of changes the practice made related to these events to improve outcomes for their patients.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. Evidence of action taken as a result was shown to us. For example, we saw that measures had been put in place following an incident involving the receipt of vaccines that were left in the administration room and not put straight into the appropriate fridge. Staff were made aware through discussions and notices displayed in the administration office of the importance of maintaining the cold chain of temperature sensitive medicines. The practice had also made the decision that this information would also be added to the staff handbook.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitors the performance of the practice told us that they did not have any concerns about this practice.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We saw that the practice had up to date safeguarding policies and staff knew how to access them. Staff also had access to the local council safeguarding policies and procedures. These provided staff with information about safeguarding legislation, how to identify and report suspected abuse. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff

knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for these agencies were easily accessible.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children who had been trained level 3 to enable them to fulfil this role. This level of training is designed to help staff become familiar with the role and responsibilities of the designated senior person for safeguarding adults and children.

A health visitor we spoke with told us that they had meetings with the practice to discuss and update the plans of vulnerable children and families. The health visitor confirmed that appropriate action was always taken by the practice whenever concerns were identified. All staff we spoke with were aware of who the lead person was and who to speak to in the practice if they had a safeguarding concern.

The practice had systems that demonstrated risks to vulnerable children, young people and adults were appropriately managed and reviewed. Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system known as SystmOne. The system collated all communications about the patient including scanned copies of communications from hospitals. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example an alert appeared when staff accessed the records of children subject to child protection plans. The system also highlighted vulnerable older patients on the practice register.

A chaperone policy was in place and information was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nurses and health care assistants. These staff were aware of their duties and showed good understanding of the purpose of chaperoning. If nursing staff were not available to act as a chaperone receptionist staff were asked to carry out this role. Training records showed that nine receptionists had also undertaken training. Receptionists we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. Two patients we spoke with told us that they had been offered the opportunity to have a chaperone present when intimate or invasive treatment was required to be carried out by a doctor.

We found that there were other reliable systems and processes in place to keep people safe which included the safe storage of prescription pads and confidential patient records.

Medicines management

There were regular reviews of medicine prescribing practices. This included a system for reviewing repeat medications for patients on multiple medications. The practice had employed a pharmacist to visit the practice weekly to identify effective and appropriate prescribing practices. The impact of this initiative had helped the practice to review their prescribing practises and reduce their medicine costs. The practice pharmacist attended the clinical governance meetings to discuss and report on prescribing practices.

We saw there were medicines management policies in place and staff we spoke with were familiar with these. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff and the action to take in the event of a potential failure was described.

We saw that processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to re-order medicines as they were due to expire.

At the time of our inspection the practice was in the process of offering the flu vaccines to vulnerable patients. To ensure the safe storage of vaccines and reduce the risk of error we saw that the vaccines for children and adults were stored in separate designated fridges. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of the directions and evidence that nurses had received appropriate training to administer vaccines.

Good

Are services safe?

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We saw that systems were in place to protect patients from the risk of infection. At the inspection the practice was visibly clean and organised. We saw there were cleaning schedules in place and cleaning records were kept. Patients told us that the health centre was always clean and fresh and presented as a hygienic environment. Patients told us that staff wore personal protective equipment (PPE) when needed. We observed that personal protective equipment was readily available and used by staff. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The senior practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw that all staff had received induction training about infection control. However an incident at the practice related to the receipt of specimens identified that not all the receptionists had received training specific to their role. We saw evidence that the lead staff member had carried out a risk assessment of the incident. Measures were put in place to address this and ensure that staff protected themselves and patients when handling specimens. The lead nurse carried out six monthly infection control audits at the practice.

Training records we looked at showed that not all staff had completed recent infection control training or updated their knowledge. Staff told us that any updated guidance was communicated to them by the infection control lead.

The practice had employed a member of staff to undertake the role of 'Clinical Housekeeper'. This person was responsible for the cleaning and maintenance of all the clinical areas related to patient care. This included cleaning and restocking of clinical rooms. Safe disposal or cleaning of medical and minor surgery equipment and the disposal of sharp boxes and clinical waste. This initiative allowed GPs and nurses to concentrate on patient care and treatment.

There were procedures in place for the safe disposal of clinical waste and sharp instruments such as needles. Clinical staff we spoke with were aware of these procedures and the arrangements in place with an external company for their safe disposal.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Patients were protected from unsafe or unsuitable equipment. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staff told us that all equipment was tested and maintained regularly. We saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence that clinical equipment was calibrated and had safety checks, for example weighing scales and blood pressure machines. Records showed that checks had been completed in June 2014.

Staffing and recruitment

We saw that the practice had a robust recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, a full work history, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. There were systems in place to check that clinical staff registrations with their professional bodies were in date.

Good

Are services safe?

The practice employed sufficient and suitable staff to meet the needs of their patients. We saw that the practice was proactive in reviewing and amending its staffing skills and levels. Staff told us there was usually enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw that there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty.

There was also an arrangement in place for members of staff, including GPs, nursing and administrative staff to cover each other's annual leave and sickness where possible. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Patients we spoke with told us that they had not experienced any problems with getting an appointment with a GP or practice nurse.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and checking equipment.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that all events and incidents that presented a risk were discussed at staff meetings. For example, the practice manager had shared the findings from a recent fire risk assessment with staff. Action was taken to address the requirements made; this included replacing the fire alarm.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients with long term conditions that had a sudden deterioration in their health had care plans developed and were visited in their homes if needed.

Arrangements to deal with emergencies and major incidents

Training records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this. Staff were aware of how they should respond to an emergency and when it was appropriate to dial 999 or call an ambulance. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Comprehensive plans to deal with any emergencies that could disrupt the safe and smooth running of the practice were in place. We saw that the practice had a business continuity and risk analysis plan. The document detailed the responsibilities of the management team and identified the action staff should take in the event of a disruption in the running of the service. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred.

A fire risk assessment had been undertaken that included the actions required to maintain fire safety. Training records showed that only five of 29 staff were up to date with fire training. The practice had recognised that there were gaps in training particularly mandatory health and safety training. We saw that plans were in place to ensure that all gaps were identified and dates set to indicate when training would be completed by.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All of the patients we spoke with told us that the clinical staff took time to explain their condition and treatment options to them. They said that they were provided with information to enable them to make informed choices and that they felt involved in decisions about their care.

We saw that the clinical staff had access to recognised best health and treatment advice. The GPs and nursing staff we spoke with were familiar with current best practice guidance. They had access to guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. GPs and nurses were aware of their professional responsibilities to maintain their knowledge so as to ensure the best outcomes for people in their care. The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Practices nurses led and managed their own clinics.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs and administration staff we spoke with and records we looked at confirmed that national standards for the referral of patients with suspected cancers were referred and seen within two weeks. We saw that these referrals were closely monitored. Minutes from meetings showed that a regular review of elective and urgent referrals was made, and that improvements to practise were shared with all clinical staff.

Two administrative staff told us that they provided students returning home from university during the term time with the opportunity to register as temporary residents. The practice informed us that they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Care plans had been put in place for two percent of the practice patients who met the criteria to avoid unplanned admissions to hospital. We saw that patients with a learning disability received an annual health assessment. At the end of the review the patient was provided with a health action plan which was agreed with them. There were systems in place that ensured babies received a new born and eight week development assessment. A GP told us that patients with mental health difficulties received an annual health review. We saw there was a referral/care pathway to enable GPs to plan the care for patients with mental health difficulties in partnership with local mental health care professionals and specialist community groups. Every patient over 75 years had a named GP and each of the 14 care homes had a named GP. We spoke with representatives from two of the 14 care homes the practice provided care and support to. They confirmed that needs assessments were completed when required.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us seven clinical audits that had been undertaken in the last four years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Following one of the audits, medication reviews for patients with chronic obstructive pulmonary disease (COPD) were carried out based on recent research and guidance. COPD is the term used for a collection of lung diseases. Some audits had repeated clinical cycles to reassess ongoing improvement. Other examples of clinical audits included audits of shoulder injection outcomes and audit of cancer diagnosis at Bridge Surgery. The outcome of audits was used as a learning tool.

The practice had also completed clinical audits linked to medicines management information, safety alerts and as a

Good

Are services effective?

(for example, treatment is effective)

result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of antibiotics. Performance data from the local clinical commissioning group (CCG) showed that the practice was overprescribing antibiotics when compared to similar practices. To address this and also to provide ongoing review of their medicine management the practice had funded the employment of a pharmacist. The practice showed us evidence of a reduction in their prescribing and medicine budget. Following the audit of medicine practices the GPs had reviewed their antibiotics prescribing practices and altered their prescribing practice, in line with the guidelines.

QOF data (and other national data returns) showed that the practice on the whole performed well in comparison to local practices. The practice had not met all the minimum standards for QOF in diabetes; however they had met their targets for asthma and chronic obstructive pulmonary disease (COPD). The data showed that the management of patients with diabetes had an increased level of risk compared to similar clinical targets. The practice had taken action to address this. One of the GPs carried out an audit on the rationale for managing diabetes better. Following this the GP and one of the practice nurses produced a leaflet for patients with diabetes on the importance of monitoring their kidney function. The leaflet provided patients with an easy to read explanation of why this test was needed. The leaflet was also an active document as the results of the tests were recorded in the leaflet.

We were told that the practice reviewed all patients recently discharged from hospital. These visits were carried out by the GPs or practice nurses according to need.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

Effective staffing

We found that most of the staff at Bridge Surgery were long serving; we did however speak with a member of staff who had started at the practice recently. They told us that they had an induction which covered the practices policies and procedures, the practice ethos and introductions to and working with other members of staff.

All clinical staff had annual appraisals which identified their learning needs, training needs and personal development plans. The practice had identified that non-clinical staff needed their appraisals brought up to date. The practice manager had plans in place to start these in November 2014. The practice used a 360 degree appraisal feedback system. This is a system in which employees receive confidential, anonymous feedback from the people who work with them. Staff we spoke with told us that they were comfortable with this method of appraisal as it helped them to identify their strengths and areas for development. Staff saw that any weaknesses identified could be supported and managed early to prevent or minimise the possibility of poor performance. Any issues of poor performance was addressed by agreement with the practice manager, lead GP and lead nurse where appropriate. The practice manager told us that an agreed action plan would be put in place to promote and encourage ongoing improvements.

We found that the process of revalidation for GPs was on going and some had already been revalidated or had a date for revalidation. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) on a regular basis that they are fit to practise and their knowledge is up to date. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). The practice checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register to make sure that they were remained fit to practice.

All staff were happy with the training opportunities offered to them by the practice. The practice was proactive in providing training and funding for staff in relevant courses to ensure they were competent in their role. The extended role of practice nurses also included seeing patients with long term conditions such as asthma, chronic obstructive

pulmonary disease, (COPD) and coronary heart disease. All of the practice nurses had completed a diploma in diabetes. To support the most recently qualified nurse to run a diabetic clinic the nurse had a buddy GP to discuss patients with. The nurses were also able to demonstrate they had appropriate training to fulfil these roles. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP buddy throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support those people with more complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. We saw that all letters related to patients were scanned so that they were available.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients including those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and saw the meetings as a means of sharing important information.

We saw that the practice worked with the district nursing teams to assist in the provision of long term condition monitoring and management of care for housebound patients. The practice worked with the community care mental health team to provide appointments at the practice for patients experiencing poor mental health.

We spoke with staff at two care homes whose patients were registered with the practice. They told us that the practice carried out regular weekly visits to the homes. They also confirmed that the GPs would visit outside these arrangements if needed and responded promptly to any concerns they had. They told us that reception staff were very polite and receptive to them when they phoned the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice told us that approximately 20 percent of referrals had been made 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).

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with. Blood and other results were received electronically and reviewed by a GP on a daily basis. The GP who reviewed the results was responsible for taking the appropriate action. Hospital discharge, A&E, outpatients and discharge letters were received either electronically or in paper format. Once the practice received the letters they were allocated to the most appropriate doctor and followed up the same day. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Information about this was available on the practice website and patients are given the opportunity to opt out of the process.

Patients were discussed between the practice GPs, practice nurses and other health and social care professionals. All the GP's met regularly to discuss the care and treatment of patients who used the practice.

The lead GP at the practice was also the chair of the local CCG. They discussed the outcome of these meetings at practice meetings in relation to performance and local initiatives to improve services for patients. This kept staff up to date with current information related to enhanced services, changing requirements in the community and adult and children at risk.

There was a practice website with information for patients. The website told patients about the services offered by the practice and signposted them to services available and

Good

Are services effective?

(for example, treatment is effective)

latest practice news. A regular patient newsletter was produced this was complemented by a 'message of the day' which was relayed through the electronic patient call systems in the waiting area.

Consent to care and treatment

Staff we spoke with had received training in the Mental Capacity Act 2005 and Children's and Families Act 2014. They demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We saw examples of how young people, patients with a learning disability, mental health difficulty or dementia were supported to make decisions. For example, there were easy read leaflets and health action plans to enable patients with learning difficulties to understand their planned treatment and care.

We saw evidence that patients were supported in their best interest with the involvement of other appropriate health and social care professionals, carers or families where necessary. For example, the practice nurse had identified that there was no clear procedure in place at the practice for obtaining consent when giving flu vaccines at care homes. A risk assessment was completed and a meeting was held at the practice at which all GPs were present. Measures taken to action this included the development of guidelines for practice staff to follow when providing treatment to patients living at a nursing home who may lack capacity.

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We saw that patients had signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations.

The GPs and nurses we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

When a person does not wish to be resuscitated in the event of severe illness a 'Do not attempt resuscitation' (DNAR) form is completed to record this in their records to protect them from the risk of receiving inappropriate treatment. This form was discussed and completed for patients included in the new avoidance of hospital admission enhanced services. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We spoke with a representative from two care homes that the practice provided care and support to. They confirmed that DNARs were reviewed by GPs from the practice and that GPs reviewed new DNARs that had been put in place whilst a patient was in hospital.

Health promotion and prevention

All new patients were offered a consultation and health check with one of the healthcare assistants. Information documented included details of the patient's mental and physical health, lifestyle in relation to their family life, environment, diet, smoking and alcohol and drugs dependency if appropriate. The patients' blood pressure and weight was also checked.

The practice offered NHS Health Checks to all its patients aged 40-75. We saw that this was promoted on the practice website, in information on a well maintained notice board in the waiting area and in the practice leaflet. The practice nurse confirmed that any patients, who had risk factors for disease identified at the health check were seen by a GP and scheduled for further investigations where necessary. Well women and well men checks were available for patients on request.

The practice nurses and health care assistants offered healthy living advice and support to patients. This included referrals to weight watchers and physical activity exercise classes for patients who needed a weight management

Good

Are services effective?

(for example, treatment is effective)

programme. Practice was also part of the local smoking cessation campaign 'TimetoQuit'. This involved the patient being part of a free 12 week one to one support programme.

The practice offered a full range of immunisations for children in line with the Healthy Child Programme.

Flu vaccines, travel vaccinations and the shingles vaccination were also offered in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group (CCG), and again there was a clear policy for following up non-attenders by the practice nurses.

Family planning services were provided by the practice for women of working age. All three of the practice nurses were trained in performing cervical smears. The practice's performance for cervical smear uptake was on target with the requirements of the CCG. Patients who did not attend for cervical smears were offered various reminders, telephone, letter for example and the practice audited non-attenders annually. Chlamydia screening kits were available for young patients to access discreetly.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check. We were informed that 56 patients with a learning disability were on the register at the time of the inspection. All had had an annual health check carried out.

The practice held a register of all patients with a severe mental health problem. These patients received an annual physical health check by the practice. Staff confirmed that they worked closely with the local primary care mental health team to support patients who were experiencing poor mental health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received two completed cards and both were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 11 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

The reception desk was located in an open waiting area. Two patients told us that this could be difficult when they needed to discuss private information with staff as other patients could overhear. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw occasions when there was a queue at the reception desk and patients could easily be overheard. The practice manager told us that access to a consultation room could be made available for patients to talk to staff in private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager.

The data from the national patient survey 2014 showed that over 90% of practice respondents (above the Clinical Commissioning Group's weighted average) said they had confidence and trust in the last GP and nurse they last saw or spoke with at Bridge Surgery.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 GP national patient survey showed that over 92% of practice respondents said the GP involved them in care decisions. This result was above the CCG area average. The practice had completed two surveys. These included the piloting of the Friends and Family Test in September 2014 which showed that 78% of patients would be extremely likely to recommend the practice to their family and friends. The second survey was carried out by an external organisation in November 2013 which allowed the results to be compared nationally. Results from this showed that overall patients were happy with the service they received. For example 85% of respondents were happy with the explanations they received about their care and 88% said that they were shown respect. The key issues for patients were access, choice of GP and waiting times for appointments. The practice was seen to be taking steps to address these issues.

Staff told us that patients were encouraged to take responsibility for their health and to be involved in decisions about their treatment. Patients we spoke with confirmed that they were included and helped to make decisions about the care and treatment they needed. The practice had undertaken care planning as part of a national enhanced service initiative, to avoid unnecessary hospital admissions. Progress on this initiative showed that at the end of September 2014, 174 patients, just over 2% of their adult population were on the case management register and care plans had been completed for all these patients. GPs had visited patients in their homes and had developed the plans with the involvement of the carers family or carer as appropriate. The practice told us that they had already identified the benefits of this process for their patients. This included enhanced communication between all health care professionals, the patient and their family/carers.

Patients spoken with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 74% of respondents to the practice survey carried out in November 2013 said that when it had been needed they were helped to access support services to help them manage their treatment and care. The views of the patients we spoke with on the day of our inspection were consistent with the results of this survey information. For example, patients told us that staff responded compassionately when they needed help and provided support when required. Patients told us that they did not feel rushed during consultations and felt that they had enough time to discuss their problems.

Patients who had suffered a bereavement were referred to a local support group or other services depending upon their need. Notices and leaflets in the patients' waiting room signposted patients to the various support groups. Staff told us that families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice was aware of patients who had caring responsibilities. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. This understanding was reflected in the services provided, for example vaccination programmes for children and older people and regular reviews for people with long term conditions.

There had been very little turnover of staff during the last three years which enabled good continuity of care and improved accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. Home visits were made to local care homes by a named GP and to those patients who needed one, particularly housebound patients. All patients who needed to be seen urgently were offered same-day appointments, telephone consultations or the opportunity to 'sit and wait'.

The practice held a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs. Decisions about care planning for end of life patients were documented in a shared care record available to all health professionals involved with the patient. A copy of the care plan was located in the patient's home. The practice worked collaboratively with other agencies, regularly updated shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

Practice staff engaged with other staff in practices within the Clinical Commissioning Group (CCG) to discuss local needs and work in partnership to meet patients' needs. The NHS Area Team and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw evidence where this had been discussed and actions agreed to implement service improvements.

The practice had an active patient participation group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. They told us that they felt very supported by the practice. They said that the meetings were supported by one of the lead GPs at the practice, the practice manager and practice administrator. Minutes of meetings we read confirmed that the PPG was listened to and actions were taken by the practice in relation to any issues raised by the PPG. The minutes for a meeting held in August 2014 showed that the practice had discussed the PPG involvement in the family and friends survey. The practice had also set up a virtual PPG group in August 2011 to attract a more diverse group of patients, especially from the younger generation.

The practice had developed a dementia notice board for patients and a member of the PPG had put together a dementia resource folder which worked alongside the noticeboard. The group supported the practice when surveys were completed. The group instigated a trial of the Family and Friends survey initiative in September in readiness for its implementation in December 2014. They found that the response to this was good and supported positive changes at the practice.

The practice regularly worked with multi-disciplinary teams in the case management of patients' experiencing poor mental health, including those with dementia. They worked closely with the local mental health team to identify patients' needs and provide appropriate counselling and support. The practice was aware of the complex needs of people living with dementia. To support their care needs advance care planning was carried out.

Tackling inequity and promoting equality

The practice had recognised the needs of their different population groups in the planning of its services. For example staff told us that arrangements were in place to ensure that vulnerable groups such as patients with a learning disability, older people and people with mental health difficulties could have regular access to a GP as needed. Staff told us that patients whose circumstances made them vulnerable for example homeless people and people experiencing problems with alcohol or drugs are able to register with the practice.

Staff told us that the practice population was mainly British and English speaking with a small group of Asian and eastern European patients. They confirmed that they had access to a telephone translation service if a patient did not speak English and some staff spoke other languages. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

saw that reception staff were able to book an interpreter to support patients where English was their second language in order for them to explain their health concerns and understand the treatment proposed by the GP.

The practice premises and services had been adapted to meet the needs of people with disabilities. We saw that there was easy access to the practice and all the consulting rooms and treatment rooms were on the ground floor. There were easily accessible toilets for patients and staff and a baby changing facility. To support access for all patients there were a number of facilities to support them such as clear signage and an induction loops for patients who had a hearing impairment. This reduced any barriers to care and supported the equality and diverse needs of the patients. Following the results of a recent patient survey the seats in the waiting area were changed to provide varied and suitable seating to meet the needs of patients with varied physical health. For example chairs of different heights and with arms to provide assistance with sitting and rising were available.

Training information showed that seven of the 29 staff had completed equality and diversity training in the last 12 months. The practice manager was aware that this was one of the training areas that needed to be improved. Staff told us that all patients received the same quality of service from them to ensure their needs were met without discrimination. We saw evidence of this during the inspection where staff demonstrated a caring and supportive approach towards patients. Patients told us that that they were treated with sensitivity.

Access to the service

The practice appointment system offered patients the opportunity to have pre-bookable and same day appointments, urgent appointments, telephone consultations, call backs and home visits by the doctors or practice nurse when appropriate. The practice was open from 8am to 6.15pm Monday to Friday. Patients could book appointments by telephone, face to face or online.

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

Patients were generally satisfied with the appointments system. Six of the 11 patients we spoke with told us that at times they found it difficult to get through on the telephone to book an appointment. However all of the patients told us that they were happy with the appointments they received.

We saw evidence that the appointments system was being frequently monitored to check how the system was working. We saw that action had been taken to try to improve the issues including the introduction of an online appointments booking facility.

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 contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. All staff we spoke with were aware of the system in place to deal with complaints. They told us that any feedback was welcomed by the practice as this was seen as a way to improve the service.

We saw that information was available to help patients understand the complaints system. with details about how to make a complaint in the practice booklet and in a complaints leaflet. We saw posters that provided a summary of the complaints process was displayed in the waiting room. Detailed information on the complaints process was also available in a detailed leaflet and on the practice website.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. However they told us that they would be comfortable making a complaint and felt confident that they would be listened to and their concerns dealt with fairly.

We looked at a record of complaints received between January 2014 and July 2014. We saw that nine complaints had been received for this period. Information documented included a summary of the complaint, details of the

Good

Are services responsive to people's needs?

(for example, to feedback?)

investigation, the person responsible for the investigation, how the complaint was received and whether or not the complaint was upheld. We saw that all nine complaints had been investigated in a timely manner.

We saw that patients' comments made on the NHS Choices website were monitored. These were discussed at practice meetings where appropriate and where changes could be made to improve the service these were put in place.

We saw evidence of shared learning from complaints with staff and other stakeholders. Information we read showed that the complaints were discussed at the practice two monthly clinical governance meetings. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. We noted that the complaints received had been discussed with the patients or complainants involved as part of the investigation and followed up with a written response.

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 shared with us their vision to deliver high quality care and promote good outcomes for patients. However the practice did not have a formal five year business plan. These values were clearly displayed patient leaflets and shared with staff at staff meetings. The practice vision and values included the following aims: 'We will endeavour to treat our patients with respect and dignity and promise to try our best to address their health concerns'. The practice manager told us that changes to be made were discussed as partners and with the team of staff where appropriate. For example to support receptionist and administration staff to have time to address patient enquiries a decision was made to employ additional receptionist staff. The practice manager said that a written plan would be considered.

We spoke with 14 members of staff they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All staff told us that they felt strongly about working together as a team to provide positive outcomes for patients.

We saw evidence where the practice worked together with other key partners who had a common focus on improving quality of care and people's experiences, for example health visitors and practice nurses.

The practice was a training centre for GPs. We found that the values for promoting good practice for patients were embedded in the leadership, training and culture of the service. We saw that there was openness, honesty and transparency at a senior level in the practice. This was visible throughout the organisation and staff told us that they felt supported, valued and motivated. Staff we spoke with demonstrated their commitment to the vision of the practice to provide high quality care for patients.

Staff told us that the practice was well led and staff expressed high praise for the senior partner and practice manager. We saw that there was strong leadership within the practice. The senior management team were visible and accessible. There was evidence of strong team working. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff confirmed that they felt able to contribute to meetings and raise any ideas for improvement or issues of concern if necessary.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at four of these policies and procedures. Staff had completed a cover sheet to confirm they had read the policy and when. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice held weekly business meetings and bi-monthly governance meetings. The practice manager held regular meetings with reception and administration staff. The lead nurse held weekly meetings with nurses and healthcare assistants and regular clinical meetings were also held between the nurses and one of the GPs. We looked at the minutes from the last four governance meetings and found that performance, quality, complaints, significant events and risks had been discussed.

The practice had completed a number of clinical audits, examples of audits we saw included medicine management and pre-PSA (prostate specific antigen) testing counselling (A test used to screen for prostate cancer in men). The audit looked at whether adequate counselling was offered to patients before PSA testing either verbally or in written form. Out of fifty patient records only 30% showed any evidence of pre PSA counselling being offered. The audit also identified inappropriate PSA testing in younger age groups. Following discussions with all clinicians, which included practice nurses clear protocols were introduced to ensure appropriate counselling took place, PSA testing was safe and targeted to the correct groups. The practice planned to repeat this audit to ensure that improvements had been made.

The practice had robust arrangements for identifying, recording and managing risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example we saw a risk assessment for the receipt of vaccines into the practice.

We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to

Are services well-led?

Good

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

maintain or improve outcomes. The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 940 points out of a possible 1000 points in 2012/2013 and 700 out of a possible 900 points up to January 2013/2014. The practice told us that the reason for the decrease in QOF performance was because they had signed up to an enhanced service offered by the NHS England Area Team. As a result the practice changed their focus on preparing for the 'Avoiding Unplanned Hospital Admissions Enhanced Service' and did not actively work on the achieving the remaining points which were soon to be retired for the last 2 months of the 2013/2014 financial year.

The practice had identified that only a small number of their staff had been trained in information governance. We saw that a plan had been put in place to action this.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns. The senior partner at the practice was the chair of the of the Clinical Commissioning Group (CCG). Information from the CCG meetings were shared with staff at practice meetings.

Practice meetings were held every week and key information from these was shared with all staff. We saw minutes that showed other team meetings were held at least monthly and individual meetings for staff with their line manager. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at these meetings. All staff spoke highly of the practice manager and senior GP partner.

We reviewed a number of human resource policies, for example, induction and recruitment policies which were in place to support staff. We were shown a copy of the staff handbook that was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, suggestion boxes, complaints and had recently participated in a trial of the 'Family and Friends' survey in September 2014. We were shown information on comments received from patients between January and June 2013 which had a common theme of the waiting room not being very inviting or comfortable. The practice manager showed us improvements which had been made to the waiting area which included new chairs and redecoration. The practice also provided an update for patients on the action they had taken in response to their concerns and comments. For example we saw a newsletter for patients titled 'You Said… We Did…' The practice also posted a 'message of the moment' when they needed to alert patients to any topical issue or general concern.

The practice had an active patient participation group (PPG). The group met every two months and one of the GPs at the practice attended the meetings. The meetings were minuted and we were shown detailed minutes of the meetings held between January 2014 and June 2014. The PPG had been involved in the surveys carried out at the practice. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The results showed that patients continued to be satisfied with the consultations that they had and there were improvements from the previous year in relation to access to appointments.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff files we examined provided evidence of training completed by staff and that staff had attended appraisal meetings with their line manager. We saw that new staff including locum GPs had a formal induction programme, this involved the new member of staff shadowing staff throughout the practice and being assigned a buddy.

We saw evidence that staff had access to learning and development opportunities. Staff told us that the practice was very supportive of their training needs. However a training record we looked at showed that not all staff were up to date with training, such as fire safety and equality and diversity. The management team had acknowledged this and had planned dates for staff to attend or complete training. We saw that nurses and GPs kept their continuing personal development up to date and attended courses relevant to their roles and responsibilities for example infection control, cytology and diabetes. This ensured that patients received care and treatment based on current guidance.

The practice was a GP training practice. We found that there was a supportive GP buddying system in place for GP trainees at the practice. This system provided the GP registrars with direct access to GP support each day. The GP registrars also had their own syndicate and attended a monthly forum for networking and to share experiences. We saw that there was also a buddying system for nurses and this could be one of the GPs.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients. Minutes of meetings showed that the action required to prevent a reoccurrence of the event was to be raised and staff confirmed that these had been followed up and shared with them.