Park Edge Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Dear Dr Denise Hughes

We carried out an announced inspection visit on 07 October 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led.

Our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the surgery were visibly clean and where issues had been identified relating to infection control, action was being taken.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- People received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service was responsive and ensured people received accessible, individual care, whilst respecting their needs and wishes.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

Yours sincerely,

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

Most aspects of the practice are safe. There were standard and local operating procedures in place to ensure any risks to patients' health and well-being were minimised and managed appropriately. There was a mentoring system in place for the nurses which helped support safe nursing care. Not all procedures were embedded in practice and therefore staff were not always following them. Improvements were needed in the recording and sharing of significant events and the centralisation of documents.

Are services effective?

Good

The practice is effective.

There were systems in place to measure the effectiveness of care and treatments. Care and treatment was delivered in line with best practice guidance. Doctors and nurses were able to prioritise patients according to need and made effective use of available resources. Patients were mainly referred to secondary (hospital) care in a timely manner.

Staff ensured that patients' consent to treatment was obtained and recorded appropriately.

Systems were in place to monitor and support staff performance within the practice.

Are services caring?

Good

The practice is caring.

Patients were included in all care and treatment decisions. They were very complimentary about the care and support they received. Patients who had completed the CQC comment cards said staff were kind and compassionate and they were treated with dignity and respect.

Are services responsive to people's needs?

Good

The practice is responsive when meeting patients' health needs.

There were mechanisms in place which helped ensure staff respond to and learn lessons when things do not go as well as expected.

Complaints about the service were taken seriously and were responded to appropriately and in a timely manner. The practice had a patient participation group (PPG) and they told us the practice was committed to the welfare of the patients.

Summary of findings

Are services well-led?

Good

Most aspects of the practice are well led.

The practice was meeting people's needs in providing a service where the GP partners and nurses had specific lead responsibilities for areas of care. For example, safeguarding adults and children.

There were some systems in place and the practice was monitoring the way care was provided in order to improve the service. However not all protocols were readily available to us on the day of our inspection. These were sent to us the following day.

Summary of findings

What people who use the service say

We received 14 completed Care Quality Commission (CQC) patient comments cards and spoke with three patients on the day of our inspection. Most of the patients who had completed the CQC comments cards and those spoken with were very complimentary about the level of care and treatment they had received. Many had been patients at the practice for over 20 years.

The patients we spoke with told us they were always treated with respect. They felt the doctors and nurses tried to help them in every way. They felt listened to and included in their treatment plans. In the CQC patient feedback from the comments cards, there was a recurring theme of 'professional, excellent and efficient' in their experiences at the practice. However, we received one CQC patient comment card which was not as positive. They experienced lack of continuity of care on a number of occasions because hospital letters had not been scanned into their records in a timely manner. We spoke with the GP and acting practice manager about this concern.

Park Edge Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** They were supported by a GP specialist advisor.

Background to Park Edge Practice

Park Edge Practice is located on Asket Drive in Leeds 14.

The practice has three GP partners and one salaried GP. There are three female GPs and one male GP. This is a training practice for undergraduate doctors and for qualified doctors who wish to undertake the postgraduate qualifications to become a GP. There are three part time female practice nurses. The practice manager is on maternity leave. Her work is being covered by an acting practice manager with support from the administration team. The practice has close working relationships with the community nursing services, the hospice and Macmillan nurses who attend regular meetings with the clinical staff. In addition the Health Visitors have offices within the same building; as do the local Medicine management team this has helped forge strong links with these services.

The practice is open from 8am - 6pm Monday to Friday. The practice rents its premises within a large purpose built building. Car parking is accessible and the surgeries are all on the ground floor. When the practice is closed the Out of Hours cover for patients is provided by Local Care Direct.

The practice has a General Medical Services **(**GMS**)** contract with NHS England for delivering primary care services to local communities. Their register of patients is currently 5322 patients. Twenty-per-cent of the practice population are over 65. This is more than in other practices locally. The practice area includes some of the most deprived areas of Leeds and therefore has some specific challenges regarding chronic disease management and patients whose life expectancy is poor.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. Park Edge was part of a random selection of practices within the Clinical Commissioning Group for Leeds South and East.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

Detailed findings

- People experiencing poor mental health (including people with dementia)

Before visiting Park Edge Practice, we reviewed information we hold about the practice and asked other organisations to share what they knew. We asked the practice to provide us with a range of policies and procedures and other relevant information before the inspection to enable us to have an overview of the practice. We carried out an announced visit on 7 October 2014. During our inspection we spoke with staff including GPs, registrars, practice nurses, the acting practice manager, administration and reception staff. We spoke with three patients who used the service and a member of the Practice Participation Group (PPG). A PPG is a group of volunteer patients who meet with the practice manager and GPs to discuss the services provided by the practice. We observed how people were being spoken with and talked with carers and family members. We reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Most aspects of the practice are safe. There were standard and local operating procedures in place to ensure any risks to patients' health and well-being were minimised and managed appropriately. There was a mentoring system in place for the nurses which helped support safe nursing care. Not all procedures were embedded in practice and therefore staff were not always following them. Improvements were needed in the recording and sharing of significant events and the centralisation of documents.

Safe Track Record

The practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF) which is a national performance measurement tool showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as medicine lead and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols in their treatment of patients.

Learning and improvement from safety incidents

The practice had an open approach to investigating incidents and there were up to date policies in place. We also saw evidence that internal investigations were carried out when a significant event had occurred. We reviewed the minutes of clinical meetings. While the information from these meetings was brief, they confirmed that incidents were discussed. However, the notes did not always show what action was taken as a result or if the issue was reviewed later. Nevertheless, staff we spoke with gave details about how the service had improved following learning from a recent incident and their reflections on practices. In addition the clinical staff told us what action they and the non-clinical staff would take as a consequence of learning from incidents to improve their practice.

Reliable safety systems and processes including safeguarding

There were policies and protocols for safeguarding vulnerable adults and children. Concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible. However not all staff spoken with could name the safeguarding lead in the practice.

Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. The lead GP informed us they had participated in local safeguarding meetings for their patients, when required. We saw that alerts were placed on patients' electronic records to inform staff of any safeguarding issues for individual patients who attended for consultation.

We saw an up to date chaperone policy and protocol. We saw the records of the administration staff who had completed their chaperone training.

Medicines Management

The lead GP prescriber for medicines had meetings at the practice with a representative from the Leeds (South and East) CCG. There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. One doctor's bag was checked and we found the contents were safety sealed and in date.

Medicine fridge temperatures were checked and recorded daily. The fridges were adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridges were ever found to be out of the correct temperature range. We saw written evidence of a significant event. We saw that the policy was adhered to.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensured all clinical staff followed the same procedures and do so safely. The SOPs and PGDs we saw were in date and clearly marked, which helped staff identify and refer to the correct document. However some we requested were not readily available and when produced were out of date. The practice should ensure all guidance is readily available. So patients can be confident that they received their medicines safely and in line with guidance produced by the National Institute for Health and Care Excellence (NICE).

Good

Are services safe?

We saw on the practice web site and practice leaflet, that patients could request repeat prescriptions either on-line, in writing or in person. There was not a dedicated prescription telephone line.

When changes were requested to patients' prescriptions by other health professionals such as NHS consultants and/or following hospital discharge, the practice updated their records to reflect this.

Cleanliness & Infection Control

The practice was visibly clean. They had an infection control lead and an infection prevention and control policy (IPC). We saw evidence that staff had training in IPC and infection control equipment was available. For example, spillage kits (to enable staff to appropriately deal with any spillage of body fluids,) sharps bins, aprons, gloves and hand sanitizer and we saw hand washing guidance. The practice had procedures in place for the safe storage and disposal of needles and waste products. A needle stick injury policy was in place. This outlined what staff should do and who to contact if they suffered a needle stick injury.

We saw the trust infection control nurse had undertaken an inspection of the premises in March 2013 and had written a report and action plan following their inspection. They requested the practice reviewed the carpeting in clinical rooms and replaced them with flooring which was impervious. They had also asked that some changes were implemented in the cleaners' cupboards. We found these action points had not yet been completed in the time specified in the report. The practice had highlighted to us that cleaning practices was an area they knew needed further action. We were informed the premises were owned by Assura Buildings and as a tenant they have little influence on some aspects of the building. However there was a plan in place to make the recommended changes.

Staffing & Recruitment

The practice had a recruitment policy which had been reviewed in September 2014. We looked at the staff file for the most recent staff member employed and found it to be comprehensive and well maintained. All appropriate checks were carried out before the staff member began working within the practice. Clinical staff had recent Disclosure and Barring Service checks (DBS) in line with the recruitment policy. We checked staff files during the inspection and found them to be well maintained. They contained appropriate curriculum vitaes and references. Each file contained sufficient checks to ensure the person was suitable to carry out the duties required in their role. All staff had their clinical qualifications recorded and checked on an annual basis or on renewal of their professional registration. A recently employed member of staff said they found the induction process very helpful. All staff had appraisal documents available in their files and staff told us the process was very supportive. They were able to ask for relevant training for their role. All staff were aware of the policy for study and training leave and told us they were granted study leave in line with this process.

Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for all aspects of patient care and treatment. However on the day of our visit, some up to date protocols could not be located easily.

Areas of individual risk were identified. Posters relating to safeguarding and violence/ aggression were displayed. The appointment systems allowed for a responsive approach to risk management. For example, we were told by staff and saw information in the practice leaflet that appointments were reserved each day for "On the day" emergencies. We were told everyone was seen on the day who presented as an emergency.

Up to date emergency equipment and drugs were checked and we found they were readily available for use in an emergency. Staff spoken with and records seen, confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained in basic life support and the clinical staff in the treatment of anaphylactic shock (severe allergic reaction).

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan to help it deal with emergencies that might interrupt the smooth running of the service, such as power cuts and adverse weather conditions. We saw that staff had been recently offered and accepted, extra clerical hours to help with the current staff shortages. However we were told that more staff were currently required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

The service is effective.

There were systems in place to measure the effectiveness of care and treatments. Care and treatment was delivered in line with best practice guidance. Doctors and nurses were able to prioritise patients according to need and make effective use of available resources. Patients were mainly referred to secondary (hospital) care in a timely manner. Staff ensured that patients consent to treatment was obtained and recorded appropriately. Systems were in place to monitor and support staff performance within the practice.

Effective needs assessment

Patients were involved in decisions about their care and treatment. The clinicians were familiar with and were following current best practice guidance. New guidance from the National Institute for Health and Care Excellence (NICE) was reviewed at the regular clinicians' meetings and where appropriate, a plan made to implement into clinical practice. Individual clinicians lead on specific disease areas, such as diabetes. We saw The British Thoracic Society (BTS) guidelines informed the care and treatment of patients who suffered from asthma.

From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. Protocols from the local NHS trust were available and used to assist staff in maintaining the treatment plans of their patients.

The practice used standardised local/national best practice care templates as well as practice designed personalised self-management care plans for patients with long-term conditions. This supported the practice nurse to agree and set goals with patients these were monitored at subsequent visits.

Management, monitoring and improving outcomes for people

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice guidance to improve outcomes for people. For example, with support from the Leeds South & East CCG Medicines Optimisation Team, the medicine lead GP monitored prescriptions to ensure the practice used the most appropriate medication and followed good practice guidance, published by the Royal Pharmaceutical Society.

The practice showed us examples of care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long term conditions, whose health was deteriorating and whose conditions were less well controlled.

The monitoring mechanisms ensured the effective use of clinical supervision and staff meetings in assessing the performance of clinical staff. Appraisals were in the process of being updated for all staff. These included the GPs having clinical supervision to assess performance and staff meetings to ensure consistency within the practice. We found that staff raised and shared concerns, incidents were reflected upon and learning took place to improve the outcomes for patients.

The practice nurses told us and we saw on the computerised system, they carried out monthly monitoring of patients taking 'high risk drugs' to ensure they received their recalls to the practice. This included disease-modifying anti-rheumatic drugs (DMARDs). Abnormal blood test recalls were also followed up monthly and action taken where appropriate in consultation with the lead GP.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and up to date. They also regularly audited their clinical results and used that to inform their learning.

Effective staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff. From our review of information about staff training, we saw staff received a comprehensive induction which was fully documented and signed by the staff member and their mentor. This covered a wide range of topics such as dignity and privacy, equality and diversity as well as mandatory training and relevant surgery information.

Staff we spoke with told us about training and professional development available to them. This included time allowed to maintain their current skills and the opportunity to learn new ones. They confirmed they had received appraisals and had identified learning and development plans as part of this process. The nurses in the practice were registered

Good

Are services effective?

(for example, treatment is effective)

with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and to update their skills.

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. This included district nurses and health visitors. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us about how the practice referred patients for secondary (hospital) care. When a referral was identified, the practice always tried to book an appointment, using the choose and book system, before the patient left the surgery.

They told us that all test results and patient letters from consultants and specialists were first seen by the doctor. Necessary actions from these were identified and carried out, immediately. The letters were then administratively coded and scanned onto the clinical records. We were told that extra staff hours were being deployed to clear the back log of records which had accumulated because of long term staff sickness. The GP who reviewed the correspondence was responsible for any action required. They recorded the action required and where appropriate, arranged for the patient to be contacted and seen clinically.

We spoke with clinical staff about the how information was shared with the Out of Hours services in the local area. Staff told us that patient information received from the out of hours service was of good quality and received on time in the morning. The GP then identified any action needed and passed the information to the administrator to scan and attach to the electronic clinical patient notes. Staff told us that this normally happened on the same day the information was received.

The practice participated in a shared care protocol for some patients. This process ensured the monitoring of safety and effectiveness of medication and sharing of information between partner organisations.

Information Sharing

The practice staff worked closely with the local community nursing team. Monthly meetings were held and a member of the hospice team also attended. At these meetings, individual patients and the care they were receiving from each professional group was discussed and records updated.

The health visiting team were co-located in the surgery. We were told this fostered good working relationships.

There was a system in place to ensure the out of hours service and NHS 111 had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care. This ensured that care plans were followed, along with any advanced decisions patients had asked to be recorded in their care plan.

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Clinical staff were able to confirm how to make 'best interest' decisions for people who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians. The practice had a consent policy available to assist all staff and this provided them with access to relevant consent form templates. Patients felt they could make an informed decision. They confirmed their consent was always sought

Good

Are services effective?

(for example, treatment is effective)

and obtained before any examinations were conducted. They told us about the process for requesting and using a chaperone and felt confident that it was effective as it was always available to them when needed.

Health Promotion & Prevention

The practice nurse team led on the management of long-term conditions (LTCs) of the patients in the practice. They proactively gathered information on the types of LTCs patients present with and they had a clear understanding of the number and prevalence of conditions being managed by the practice.

We saw the 'call and recall' system and how this worked within the surgery. This helped to ensure the timely and appropriate review of patients with LTCs and those who required periodic monitoring. Patients with more than one LTC were offered one recall appointment when all care and treatment could be reviewed. This included an appointment time which was longer to improve the patient experience.

The nurses told us they printed condition specific leaflets for patients during their consultation. We also found leaflets with information relating to health promotion and any local incentives that were taking place in the coming months, were displayed in the waiting area of the practice.

We saw evidence of high levels of screening uptakes and high initial diagnosis level of patients suffering from cancer. We were told patients move to the area because they are closer to the treatment centres.

One of the GPs explained how they support patients' with mental health problems to keep physically well too. As a training practice they had discussions and deliberations with the patient and the trainees exploring individual health issues and treatment options. This, they felt helped vulnerable patients to understand better, the need to optimise their physical health as well as having their mental health issues managed effectively.

Good

Are services caring?

Our findings

The service is caring.
Patients were included in all care and treatment decisions; they were very complimentary about the care and support they received. Patients who had completed the CQC comment cards said staff were kind and compassionate and they were treated with dignity and respect.

Respect, Dignity, Compassion & Empathy
Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in consultation rooms which gave patients privacy and separate examination rooms promoted patients dignity.

We did not see any signage explaining that patients could ask for a chaperone during examinations if they wanted one. However we were told patients were asked and it was always recorded in the patient's electronic notes. Nurses and trained administration staff usually acted as chaperones.

Patients told us that all staff effectively maintained their privacy and dignity. The GP registrar we spoke with told us the partners were excellent role models as they reflected the caring ethos of the practice and provided high standards of clinical care.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We saw there was a notice in reception about courtesy and respect when patients were waiting to book in. We were told this worked well by reception staff and the Patient Participation Group (PPG) member. This was initiated at the request of the PPG.

The patients we spoke with told us they were completely satisfied with the approaches adopted by staff and felt clinicians were extremely kind and compassionate.

Care planning and involvement in decisions about care and treatment.
The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. They felt the nurses and GPs would take time to re-word information if they did not understand.

We saw care plans for patients with specific health needs. They were adapted to meet the needs of each individual. This information helped patients to manage their own health, care and wellbeing to maximise their independence. Additionally those patients who needed support from carers could be assured that their needs would be met because of the careful care planning. There was evidence that these care plans were having an impact on reduced hospital admissions.

Patient/carer support to cope emotionally with care and treatment
We were told that the monthly palliative care meetings with clinical staff, community health professionals and a member of the local hospice team discussed patients, their carers and their need for support. They felt this worked well as patients and or their carers were emotionally and physically supported to cope with their treatments. We saw evidence of other signposting in the waiting room for patients who wished to self-help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice is responsive when meeting patients' health needs.

There were mechanisms in place which helped ensure staff respond to and learn lessons when things do not go as well as expected.

Complaints about the service were taken seriously and were responded to appropriately and in a timely manner. The practice had a patient participation group (PPG) and they told us the practice was committed to the welfare of the patients.

Responding to and meeting people's needs

There was a large on-site car park. The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. All consulting rooms were located on the ground floor. There where toilets for disabled patients. There was a large waiting area with plenty of space for wheelchair users.

Staff said they had access to interpreter or translation services for patients who required it and there was guidance to follow about using interpreter services with contact details. The staff had access to leaflets in a variety of languages and could access these electronically as required. The PPG were involved in these timely changes.

Patients with immediate, or life-limiting needs, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

Tackling inequity and promoting equality

We found there was a named GP for each of the care/ nursing homes that were assigned to the practice. The named GP visited the home weekly, or more frequently if required.

Patients who needed extra support because of their complex needs were allocated double appointments. We saw specific tailored care plans to meet their needs for example patients with learning disabilities or those who suffered with dementia as well as LTCs.

Access to the service

Patients we spoke with and those who completed a CQC comment card did not have any concerns about accessing appointments. The PPG representative and one of the GPs expressed concerns about appointment availability. To address these concerns the practice was to look into the feasibility of telephone triaging for patients on the day. Also they wanted to look at different ways of extending their hours to meet the needs of some patient groups such as school age children.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We reviewed the practice policy on complaints, concerns and comments and looked at the patient complaints leaflet. We saw recent complaints and noted that further training was undertaken by a member of staff, this showed learning from complaints was taken very seriously by the practice. Complaints were dealt with in a timely way in accordance with the practice policy.

Are services well-led?

Good

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

Our findings

Most aspects of the practice are well led.
The practice was meeting people's needs in providing a service where the GP partners and nurses had specific lead responsibilities for areas of care. For example, safeguarding adults and children.

There were some systems in place and the practice was monitoring the way care was provided in order to improve the service. However not all protocols were readily available to us on the day of our inspection. These were sent to us the following day.

Vision and Strategy

There was an established management structure within the practice. The acting practice manager, GPs and staff we spoke with were clear about their roles and responsibilities. The practice was committed to deliver a service where patient care came first. However, they were aware that their current model was unsustainable and they were pro-actively working with the CCG and other practices locally to ensure their vision of primary care continues.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. Most of these were available to all staff in paper copy in the reception office. We looked at 21 of these policies and procedures and found they covered the relevant areas in sufficient detail and incorporated national guidance and legislation. They had been regularly reviewed and updated. We also found clinical staff had defined lead roles within the practice, for example, for the management of long term conditions.

The practice held regular meetings where governance, quality and risk were discussed. We saw the most recent notes of these meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that the clinical team regularly discussed QOF data at team meetings and through appraisal sessions.

Leadership, openness and transparency

The current practice manager was on maternity leave and the acting manager had not had any experience of practice management. They will need help and support to maintain the positive level of engagement that the substantive practice manager has had, developing policies and protocols.

All staff and trainees spoken with told us that all members of the management team were approachable. They were encouraged to share new ideas about how to improve the services they provide. Staff spoke positively and passionately about the practice and how they worked collaboratively with colleagues and health care professionals.

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

The practice had gathered feedback from patients through the patient participation group and patient surveys. We reviewed the most recent data available for the practice on patient satisfaction which was from February 2013. This included information from the national patient survey. The evidence from this demonstrated that patients were satisfied with the care and treatment provided by the practice and how they were treated. Results on the NHS patient survey were all similar or better than expected when compared with other practices.

We did not see any staff surveys. Staff we spoke with told us they attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and to raise any concerns they had. They also told us how the staff sickness was impacting on the service provided. The GP and acting practice manager highlighted to us what they were doing to address these shortfalls, such as working with the CCG to identify administrative cover.

The PPG had very few members and this was highlighted as an area of concern by the practice. They were to take further steps to encourage more patients to become involved. They were considering using a 'virtual PPG' to see if this would attract more volunteers. The PPG member we spoke with felt the GP partners did listen to their views and welcomed feedback to inform how the practice could best meet the needs of their patient groups.

Management lead through learning & improvement

We found that trainees and GPs were striving for continuous learning, improvement and innovation. Clinical

Are services well-led?

Good

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

meetings where, were up to date medical practice was discussed. One of the recent changes discussed and implemented was the additional personalisation of the care plan templates to meet patient's needs.

We were told that the practice staff learnt together on target days and also when mandatory training was undertaken such as basic life support.

We also saw the detailed plan for sustaining good clinical practice was implemented when a recent adverse incident occurred. We saw that protocols and best practice guidance was followed and shared with all members of the clinical team.