Bartongate Surgery

Quality Report

115 Barton Street
Gloucester
GL1 4HR

Tel: 01452 422944
Website: www.bartongatesurgery.co.uk

Date of inspection visit: 13 January 2015
Date of publication: 19/03/2015

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

Overall summary

Letter from the Chief Inspector of General Practice

Bartongate Surgery is situated in the inner city area of Gloucester with approximately 9000 registered patients. Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Gloucester Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We undertook a comprehensive announced inspection on 13 January 2015. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for all of the population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

- Bartongate Surgery was proactive with future planning and development of services for patients and had introduced a triage system by a nurse practitioner which improve access to medical consultations for patients.
- The practice participated in innovative pilot programmes such as the Choice Plus project which increased patient access to urgent care appointments and chronic illness management.
- We were told special arrangements had been put into place by the practice for dealing with an expected death of a member of the local Muslim community which allowed for immediate funerals.
- The practice hosted regular meetings for carers and a specific six monthly open access clinic run by one of the GPs supported by the administrative team.
- Bartongate surgery had a weekly drop in clinic for young people aged 13 years and over who can be seen for confidential health and lifestyle advice. This service is open to all young people and not just those registered with Bartongate surgery

Action the provider SHOULD take to improve:

- The practice should have a patient participation group.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. We found the practice had systems, processes and practices in place to keep people safe and these were communicated to staff. Staff understood their responsibilities to raise concerns and incidents. Safety was monitored using information from a range of sources and we found improvements had been made when things went wrong. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice also had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for effective. The practice demonstrated patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate prescribed treatment. We found staff had the skills, knowledge and experience to deliver effective care and treatment. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for minor surgery.

Are services caring?

Good

The practice is rated as good for caring. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they receive care and treatment. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted upon such as paying for taxi transport home for patients who were poorly. The practice took into account patients' cultural, social and religious needs for example, language interpreters were available if needed.

Summary of findings

We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients who used the practice fed back that they were routinely involved in planning and making decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. It reviewed the needs of its local population and engaged with the NHSE Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. The practice was responsive to changing risks for people who use services, including deteriorating health and wellbeing or medical emergencies. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues 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. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff, and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients via surveys. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people in its population and had a range of enhanced services, for example, the practice ensured the frail older patients were assessed for their potential risk of unplanned admissions and planned care to avoid them. It was responsive to the needs of older people and offered home visits to those unable to get to the practice.The practice also supported older patients living in residential or nursing homes locally.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice provided specialist nurse support for conditions such as asthma, diabetes and heart disease. Patients' conditions were monitored and reviewed with planned appointments sent directly to them. We found patients were assessed and signposted to the most appropriate support. Vulnerable patients had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The care plan was made available to the Out of Hours service. For those people with the most 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young patients who had a high number of A&E attendances. Patients told us and we saw evidence that children and young patients were treated in an age appropriate way and 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 made for children and pregnant women who had a sudden deterioration in health. The practice liaised with a range of other agencies regarding patients for example, the sexual health clinic. Young adults were able to access confidential appointments with a GP and a weekly drop in clinic.

Summary of findings

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 was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice could refer patients to the community health trainers to offer local support to patients to improve health and well-being.

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. For example the practice provided medical services to a local bail hostel. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients living with dementia.The data provided by the practice showed a high level of need for patients with severe mental illness. The practice had nurse led mental health care sessions twice weekly to meet this need. The practice also sign-posted patients who experienced poor mental health to various support groups or as appropriate to psychological therapies and self-help groups, and provided one-to-one support. Staff had received training about how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with four patients visiting the practice and we received two comment cards from patients who visited the practice. We also looked at the practice NHS Choices website to see comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the last Care Quality Commission inspection report about the practice.

The comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about seeing their preferred GP at most visits and about being involved in the care and treatment provided.

We reviewed the results from the national GP Patient Survey for 2013 and found the responses did not confirm the experience we heard from patients. The survey had found the proportion of patients who would recommend their GP surgery was 73% which was below the average for the Clinical Commissioning Group (CCG). This was not reflected in the comment cards which had been completed as in the national GP Patient Survey 93% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. This was above the CCG average of 90**%** and 93% of respondents say the last GP they saw or spoke to was good at giving them enough time again this was above the CCG average of 90**%**.

The practice had also commenced their current 'friends and family' survey; the results indicated over 80% would recommend the practice. Bartongate Practice participated in other patient focussed reference groups within the CCG area.

Areas for improvement

Action the service SHOULD take to improve

The practice should have a patient participation group.

Outstanding practice

We saw several areas of outstanding practice including:

- Bartongate Surgery was proactive with future planning and development of services for patients and had introduced a triage system by a nurse practitioner which improved access to medical consultations for patients.
- The practice participated in innovative pilot programmes such as the Choice Plus project which increased patient access to urgent care appointments and for chronic illness management.
- We were told that special arrangements had been put into place by the practice for dealing with an expected death of a member of the local Muslim community which allowed for immediate funerals.
- The practice hosted regular meetings for carers and a specific six monthly open access clinic run by one of the GPs supported by the administrative team. The GP had been involved with carers from the local community over several years and had been nominated for awards and achieved recognition for their work through the honours process.
- Bartongate surgery has a weekly drop in clinic for young people aged 13 years and over who can be seen for confidential health and lifestyle advice. This service was open to all young people and not just those registered with Bartongate surgery

Bartongate Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor.

Background to Bartongate Surgery

Bartongate Surgery is situated in the inner city area of Gloucester. It has approximately 9000 patients registered with a range of cultures and ethnicity with a high number of patients from black and minority ethnic communities (approx. 40.35 % of registered patients). There is a telephone interpretation service available onsite to assist with any translation issues.

The practice operates from one location:

Bartongate Surgery

115 Barton Street

Gloucester

GL1 4HR

The practice is made up of six GP partners and two salaried GP's of both genders working alongside two qualified nurses and one health care assistant (all female). The GPs provide 39 sessions each week. The practice has a personal medical services contract with some additional enhanced services such as extended hours for pre booked appointments and unplanned admission avoidance. The practice is open on Monday to Friday 8.30am - 1.15pm and 1.45pm – 6pm, and pre booked appointments are available on Tuesday and Thursday evenings between 6.30pm - 8pm and on some Saturday mornings between 9.00am – 11am. There is always a GP on site whenever the practice is open.

The practice does not provide out of hours services to its patients, this is provided by South Western Ambulance Service NHS Foundation Trust in partnership with the Gloucestershire GP provider company Limited. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years 8.13 %

5-14 years 14.94 %

15-44 years 44.13 %

45-64 years 21.73 %

65-74 years 5.55 %

75-84 years 3.93 %

85 years + 1.6 %

The practice is in an area of high deprivation with the Index of Multiple Deprivation at 33.26 which is over twice the clinical commissioning group average of 15.05. Living in relative poverty means that families tend to make lifestyle choices that are less healthy than those made by more affluent families. The impact for the practice was that they have a ratio of 7.1 appointments per patient per year which is above the national average of 5.3. The practice has a low number of patients over 75 years (less than 500) compared to the CCG average, but high numbers of patients living with long term conditions. The patient gender distribution was male 52.34 % and female 47.66 %; GPs of both genders work at the practice.

Detailed findings

The practice was previously inspected by the Care Quality Commission (CQC) on 23 January 2014 and was found to be compliant in the five outcome areas that were inspected.

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Gloucester Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 13 January 2015 between 9am - 5pm.

During our visit we spoke with a range of staff, including GPs, nurses, the practice manager and administrative staff.

We also spoke with patients who used the service. We observed how patients were being cared for and reviewed the patient information database to see how information was used and stored by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older patients (over 75s)
- Patients with long term conditions
- Mothers, children and young patients
- Working age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing poor mental health.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, incident reporting, national patient safety alerts and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed the practice safety record and incident reports which showed no major incidents indicating the practice had managed safety consistently over time. The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the GP or nurse to significant issues relating to that patient and their care. For example, the practice had a child protection coding process to ensure practitioners were alerted if patients had a protection plan. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record.

The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Gloucester Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last year, and we were able to review these with individual GPs. Significant events were a standing item on the practice meeting agenda. The significant events were recorded in each GPs professional training and development record and we were able to read the actions from past significant events. There was evidence the practice had learned from these, however the practice did not record how the learning was shared with relevant staff.

National patient safety alerts were disseminated by the practice manager to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. We were told how the practice had responded to the NHS England alert in relation to the Ebola outbreak and people travelling from West Africa. The practice had shared information with all staff to ensure they understood their role and the processes the practice had in place to identify and respond to any potential cases. Staff we spoke with told us this had increased their knowledge about the issue and the action they needed to take. We also observed the practice had an information board dedicated to the presentation and treatment of Ebola for both staff and patients.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training about 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 and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role, for example, GPs were trained to level 3 in child protection. All staff we spoke with were aware who the lead staff were and who to speak to in the practice if they had a safeguarding concern. The practice demonstrated appropriate liaison with partner agencies such as the police and social services and held monthly meetings with health visitors and midwives, where any risks were discussed and action agreed.

There was a system on the practice's electronic records to highlight vulnerable patients.. This included information to make staff aware of any relevant issues when patients attended appointments, for example, failure to attend for childhood immunisation.

Good

Are services safe?

We observed there was a chaperone policy, which was displayed on the waiting room noticeboard and in consulting rooms. Nursing staff and reception staff were available to act as a chaperone, and had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We were told there were very few requests for this service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators There was a clear policy for ensuring medicines were kept at the required temperatures. It also described the action to take in the event of a potential electrical failure. There was evidence that practice staff followed the policy.

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. We saw there was a system in place to monitor the small number of medicines the GPs kept in their bag for home visits. The practice did not have any controlled drugs.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We spoke with the health care assistant who told us about their training in order to administer vaccines. We were also told about the processes they followed to ensure they were legally permitted to administer the vaccines.

The practice benefitted from the overview of prescribing practice by a pharmacist. We saw there had been audits undertaken in response to medical alert information and guidance which resulted in prescribed medicines being reviewed. For example, in April 2014 the practice had received information from the CCG which identified 92 patients who could be prescribed generic medicine instead of proprietary brands. We saw this had been enacted for 76 patients which generated savings for the practice without adversely affecting patients. We also heard the pharmacist was helpful in identifying the content of medicines so that patients who were Muslim could be assured they were taking medicines in accord with their faith.

There was a system in place for the management of high risk medicines, for example prescribing benzodiazepines. GPs and nurses were responsible for monitoring the effectiveness of diagnostic testing. An alert was placed on the computer system to ensure relevant tests had taken place and it was safe for the patient to continue taking prescribed medicine.

The practice planned to introduce an electronic prescription service available which allowed prescriptions to be sent to a patient's nominated pharmacy. Patients ordered repeat prescriptions in person or online. The practice set a target of getting medicines to patients within 48 hours. We were told that if needed the practice was flexible and patients could request medicines and have a repeat prescription within a very short time frame.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. 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 generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary. This was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any changes.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Hand hygiene technique 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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse manager took lead responsibility for infection control and told us the practice infection control policy was under review. All staff received induction training about infection control specific to their role; further updates were arranged by the practice nurse manager. We

saw evidence there had been an audit of precautions and systems in December 2014. Improvements identified for action were completed. The infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. We also saw the practice had received the NHS England information relating to the Ebola outbreak in West Africa and ensured this information was available to staff and patients. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings).

Equipment

The practice was suitably designed and adequately equipped. The fabric, fixtures and fittings of the building were maintained by the practice who had employed a handyman and specialist contractors as needed. We saw equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED is used to attempt to restart a person's heart in an emergency) centrally located and all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers indicating testing. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice manager who arranged for its repair or replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss and to maintain patient confidentiality.

Staffing and recruitment

The practice had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice was located in a purpose built environment .The maintenance of the building and external grounds, and the health and safety arrangements for the building were managed by the practice. We were shown the systems, processes and policies 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 equipment. The practice also 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.

We saw risks were discussed at GP partners' meetings and within team meetings. For example, the practice monitored repeat prescribing for patients receiving medicines for mental health conditions. We saw a range of information was available in the practice which provided details of organisations, patients or staff could contact if physical health emergencies or mental health crises occurred, either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available.

Good

Are services safe?

Staff told us how they recognised and responded to changing risks to patients and staff. Staff told us they had recently been trained in what to do in an urgent or emergency situation and about the practice's procedures in such circumstances.

Arrangements to deal with emergencies and major incidents

We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found no recent accidents had occurred at the practice. Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. The practice held a list of the medicines' expiry dates and had a procedure for replacing medicines. Staff knew where emergency medicines were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, for example, through poor mobility or where epilepsy was diagnosed. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived. The practice had arrangements in place to manage emergencies. All staff had completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used. Emergency equipment was available including access to oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Emergency appointments were available each day both within the practice and for home visits. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The document also contained relevant contact details to which staff could refer. For example, contact details of the computer system supplier in the event of failure.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk assessment. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records which showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told by the practice nurse manager that all protocols for the nurses were reviewed to reflect the latest good practice. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice manager and senior partner told us they assessed the needs of the patient population and recruited staff to lead in specialist clinical areas such as diabetes, chronic obstructive airways disease and asthma. For example, we were told the practice had recruited a practice nurse manager with expertise in respiratory conditions. Through our discussions, we found the practice had 501 patients registered as being diagnosed with diabetes; a specialist diabetes practice nurse had been recruited to support this work. The senior partner told us this supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions.

The practice used medical risk assessment programmes to identify patients with complex needs and who had care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients recently discharged from hospital were reviewed within 48 hours by their GP. according to need.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and administrative team to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the practice recently. We read an audit relating to the blood testing process for patients taking anticoagulant therapy. The practice re audited and was able to demonstrate the changes in the testing process had not impacted on patients outcomes. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so according to their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit of patients with a diagnosis of diabetes and renal impairment who were taking a medicine which put them at risk of developing lactic acidosis. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, to meet the prescribing guidance. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved 95.3% of QOF points which was 1.8% above the England average. This practice was an outlier

Good

Are services effective?

(for example, treatment is effective)

(where achievement was outside the accepted national range) for two areas; for prescribing of hypnotic medicines and one aspect of diabetes management. We found both of these to be under scrutiny by the practice who had taken action to improve performance. They had worked with the CCG pharmacist to review all patients prescribed this type of medicine. In respect of diabetes, the practice had a higher than the national average prevalence and so had recruited a nurse with specialist training in diabetes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of practice. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice of involvement and how they could contribute to improvements to the service.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked all routine health checks were completed for patients with long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving 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 the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed training records and saw that staff had completed mandatory courses such as annual basic life support training. We noted a good skill mix amongst the GPs who had achieved a range of additional medical qualifications in a specialist areas such as paediatrics and child health, gynaecology and family planning and reproductive healthcare. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated, or had a date, for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. We were told about the training offered to the nurses to allow them to extend their professional role. For example, the health care assistant had received additional training to be able to undertake smoking cessation clinics. The practice supported placement for medical students in conjunction with the Bristol deanery.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, in administration of vaccines, we spoke with the heath care assistant who confirmed their training and understanding of the specific patient directives required to complete this treatment. The nurse practitioner who undertook the triage of patients requesting urgent appointments was supported by, and given clinical supervision by, the GPs. Those with extended roles for assessing and monitoring long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no examples identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service for emergency admission avoidance and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice had a system to monitor follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with children on the 'at risk' register. These meetings were attended by health visitors and decisions were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP 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 made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had signed up to the electronic Summary Care Record and included information for patients about the system on their website. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Act 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the GPs told us they supported patients to make their own decisions and documented this in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in compiling. These care plans were reviewed annually or frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and placed in the electronic patient notes, with a record of the relevant risks, benefits and complications of the procedure. We saw patients were also given information about the post-operative care of the site.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the Clinical Commissioning Group to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted the culture at the practice was to use their contact with patients to help maintain or improve mental and physical health and wellbeing. This was reflected by the information available to patients in the waiting room. There were information boards dedicated to a specific subject. We also observed chlamydia screening kits were readily available to patients.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 100% were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support according to their needs.

The practice's performance for cervical smear uptake was 87.5%, which was lower than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

Population Groups evidence

Older people

There was a register kept of patients who were identified as being at high risk of admission or needing End of Life care; they had up to date care plans which were shared with other providers.

Patients discharged from hospital had a follow-up consultation under the enhanced service provision.

100% of patients received structured annual medicines reviews for polypharmacy.

There was evidence of multidisciplinary case management meetings.

We found provision of a named GP for all patients over 75.

People with long term conditions

We found structured annual reviews for various long term conditions e.g. Diabetes, Chronic Obstructive Pulmonary Disease and Coronary Heart Disease.

The practice had adopted Summary Care records.

There was evidence of multidisciplinary case management meetings.

We found provision of a named GP for all patients over 75.

Families, children and young people

There was evidence of signposting young people towards sexual health clinics and of offering extra services.

There was evidence of multidisciplinary case management meetings with midwifes, community nurses and health visitors.

Working age people

There was flexible access for appointments so patients could be seen when not working.

The practice achieved 100% of the QoF target for cardiopulmonary disease prevention.

People whose circumstances may make them vulnerable

The practice holds a register of those in various vulnerable groups e.g. learning disabilities.

People experiencing poor mental health

The practice achieved 100% of people with severe mental illness who received an annual physical health check.

We found evidence of staff undertaking co-working with mental health services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey for 2013, a survey of 423 patients undertaken by the practice. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 86.46% of patients felt that their overall experience was good or very good. The practice was also above the Clinical Commissioning Group average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk to keep patient information private. The reception desk was also separated from the waiting room. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that 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 practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance to abusive behaviour. We discussed with the practice manager the systems in place for addressing such behaviours whilst acknowledging some of the patients who were registered at the practice had multiple problems which may influence their behaviour. We were told about a recent incident with a person who was not registered with the practice but was known to them, and heard how the situation was dealt with sympathetically. We also found for some patients whose circumstances may make them vulnerable, such as the patients living at a local bail hostel, the practice made arrangements to visit the site and see patients there.

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 national patient survey showed 85% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results which was above average compared to Clinical Commissioning Group area.

Patients we spoke 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.

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 patients this

Good

Are services caring?

service was available. We also found that the self-check in service was available in a wide variety of languages. The practice waiting area had information in different languages and the website could be translated.

We found that the 2% of the population identified as vulnerable had their own care plan. We looked at these and noted personal choices about where they preferred to receive care had been recorded. The plans we read had been signed and agreed by the patient.

Bartongate surgery had a weekly drop in clinic for young people aged 13 years and over who were seen for confidential health and lifestyle advice. The service was open to all young people whether they are registered at Bartongate surgery or not. This was advertised on the practice website which would be an accessible medium for young people.

Patient/carer support to cope emotionally with care and treatment

The patients and staff we spoke with on the day of our inspection and the comment cards we received gave examples of how the practice was caring towards its patients. We were given examples of individual GPs paying for transport for patients who were unwell. We were also told how patients were treated as individuals who may not fit or understand systems. For example, we heard that if patients with chaotic lifestyles arrived at the practice staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice had good links with specific services in the local area and we were told they attended various working groups which targeted reducing inequality.

One of the GPs acted as a carer's champion for the practice, their innovative work had been recognised nationally. The practice's computer system alerted GPs if a patient was also a carer. All carers were therefore identified and sent relevant information about the six monthly drop in clinic run by the carer's champion. The practice also hosted representatives from statutory and voluntary agencies to these clinics to offer carers advice. The practice had a dedicated noticeboard where we found written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice about how to find a support service. We were told that special arrangements had been put into place by the practice for dealing with an expected death of a member of the local Muslim community which allowed for immediate funerals. The practice also had clear step by step information on their website of the action for relatives following the death of a patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had recognised the needs of different groups in the planning of its services. For example, the young person's drop in clinic, the clinic held at the bail hostel and the regular visits to two local nursing homes. All of which enabled patients who were vulnerable and required support, to receive medical care. We were told by the practice that patients of "no fixed abode" could not register at the practice however, the practice had registered patients who had a contact address which may not have been their permanent place of residence.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services, information was produced in different languages. We found the self-check in service was available in a range of languages. The practice had a high number of patients from the West Indies who had immigrated to the UK. We saw the practice had a health education information board in the waiting room which targeted prostate cancer in male Jamaican patients. We were told this was the most prevalent cancer in this population group and this campaign was to encourage male patients to attend for screening.

The practice had their equality and diversity statement on their website. The practice provided equality and diversity training and staff we spoke with confirmed they had completed the training We also saw that administrative staff had attended customer care training in the last 12 months to enhance the service to all their patients.

The premises and services had been adapted to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The practice was situated on the first and second floors of the building with services for patients on the ground floor.

Access to the service

The practice was open on Monday to Friday 8.30am-1.15pm and 1.45pm – 6pm. The practice's extended opening hours on Tuesday and Thursday evenings between 6.30pm -8pm and on some Saturday mornings between 9.00am – 11am, which was useful to patients with work commitments. There was always a GP on site whenever the practice was open. The practice did not provide out of hours services to its patients but information about the out-of-hours service was provided to patients.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

The practice operated a triage system for patients who requested an urgent appointment. The requests were triaged by a nurse practitioner through telephone consultations. Patients were directed to the most appropriate care. The practice had a higher than average rate of 'Did not Attend' and had undertaken an audit to try and improve attendance and reduce wasted appointment time. We read that for a period of three months from 1 January – 31 March 2011 the average number of hours lost for GPs was 8.8 hours and for nurses 10.1 hours. The practice put in measure to reduce this and the latest audit for January – March 2014 was hours lost for GP time was 7.3 hours and nurse time 9.3 hours. The practice will be introducing an online booking system by 31 March 2015 and are trialling text message reminder for appointments. Patients were generally satisfied with the appointments system. They confirmed , if needed, they could see a GP on the same day. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was part of a pilot scheme called Choice Plus. This meant that patients registered with the practice could access on the day appointments at the local walk in centre, the agreement was that the practice could access up to 27 appointments each week. This freed up time for the practice GPs to concentrate on the management of patients with chronic illness. This in turn linked to other projects such as the admission avoidance enhanced service which ensured patients with these conditions had their own care plan which was regularly reviewed.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition, or required translation services. This also included appointments with a named GP or nurse. The patient record system had an alert which indicated patients who required longer appointments. Home visits were made to two local care homes on a specific day each week, by a named GP. The practice also responded to requests from patients unable to go to the surgery, for home visits. One GP was allocated an afternoon each day to undertake these visits. We were told by the practice manager and senior partner that this arrangement worked well as it stopped duplication of travel, as well as allowing sufficient time for visits to be made without needing to return to the practice for afternoon surgery. Any time not spent on urgent home visits was used by GPs to make additional visits to chronically ill patients.

Appointments were available outside of school hours for children and young people. In addition the practice offered a weekly drop in clinic for young people aged 13 years and over who can be seen for health and lifestyle advice. Specialist clinics were arranged for childhood immunisations.

We also found that the practice had prioritised vaccination against influenza for patients who met the criteria, for example, older patients and pregnant mothers. However, we saw the practice had kept a list of non-priority patients who had requested the vaccination and had provided this service using the excess stock.

For patients who experienced poor mental health the practice had identified this was a level of growing need with 110 patients experiencing severe mental illness and a high prevalence of depression. The practice worked in partnership with the 'Let Us Talk' service. This offered an integrated approach to mental health provision as patients could be assessed and treated at the practice by a mental health nurse. We were told by the mental health practitioner this flexible service enabled patients, GPs and nurses to have good communication and have a holistic approach to patient care.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both in the practice and on the website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at the five complaints received in the last 12 months and found these were satisfactorily handle and dealt with in a timely way. The surgery had followed its own policy when handling complaints. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn. Information about how to complain was available in the waiting room and on the practice website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and future plans. The practice objectives were outlined in their statement of purpose and included ensuring patients are receiving and experiencing a high standard of care and stating the practice's commitment to the continuous improvement of patient centred care. The practice values included understanding and meeting the needs of patients, by involvement and encouragement to participate fully in their care.

We spoke with four members of staff and they all spoke about the vision and shared the values of providing responsive, compassionate care to patients. Staff were enthusiastic and excited about working at the practice and of the contribution they made to patients health and well-being.

Governance arrangements

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

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The member of staff who monitored performance told us about the regular checks undertaken to ensure that patients had received the reviews and tests they needed. We were told that if there were any deficits then the GPs and nurses would be made aware of this and action to remedy the situation would be taken. We also discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the 'Avoiding Unplanned Admission' service meant the practice was proactive in identifying vulnerable patients, and ensured care plans were in place and were reviewed. Although for the member of staff these were administrative tasks it was apparent that the practice worked as a team to promote the good health and well-being of patients.

The senior partner told us about a local peer review system they took part in with neighbouring GP practices. This enabled the practice to have an opportunity to measure its service against others, share good practice and identify areas for improvement.

The practice had an on going programme of audits, clinical and non-clinical which it used to monitor quality and systems to identify where action should be taken. For example, we saw a review of the triage system for access to appointments had been audited to ensure sufficient resources were deployed to meet demand.

The practice had arrangements for identifying, recording and managing a range of risks. We saw that the risks to the practice were discussed at the management 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, the practice had undertaken risk assessments of the chemicals used in the practice to ensure relevant information was available and they were safely stored.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We were also told there was no sense of hierarchy amongst the team and that more senior staff were very approachable. We also heard how staff were

Are services well-led?

Good

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

encouraged to contribute to solutions for issues that affect the practice. For example, there was delegation of key responsibilities to both clinical and non-clinical staff such as health and safety monitoring.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown the section on the practice computer network that was available to all staff, which included sections about equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had gathered feedback from staff through staff meetings, appraisal and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they had asked for specific training to be able to act as a chaperone and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not have a patient participation group.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with GPs and staff and saw that regular appraisal took place which included a personal development plan. Staff told us the practice was very supportive of training. We saw a programme of protected time was planned for clinical staff for reviewing various areas of practice and where guest speakers and trainers attended. The practice offered placements to medical students from the local deanery.