

# Bridge House Medical Centre

## Quality Report

Scholars Lane  
Stratford Upon Avon  
Warwickshire  
CV37 6HE  
Tel: 01827 713664  
Website: [www.bhmc.co.uk](http://www.bhmc.co.uk)

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

### Ratings

#### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected this service on 5 March 2015 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

### **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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and well managed. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems were in place that ensured the safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. There were enough staff to keep people safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Clinicians worked to the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness. They produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

Patients' needs were assessed and care planned and delivered in line with current legislation. Clinicians had carried out clinical audits and made changes where necessary to promote effective treatments for patients. Systems were in place for regular reviews of patients with long term conditions, those identified as at risk and housebound patients. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could show that appraisals and personal development plans had been completed for all staff. Staff worked well with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Information to help patients understand the services available to them was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice understood the needs of the population groups registered with them and were proactive in planning services to meet their needs. Patients told us they could get an appointment with a named GP or a GP of their choice, with urgent appointments available the same day. The practice had good facilities and was well equipped to assess and treat patients in meeting their needs. Information about how to complain was available and easy to understand and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Good



## Are services well-led?

The practice is rated as good for being well-led. The practice prioritised the provision of quality and caring services for all their patients. All practice staff worked together to achieve this. Staff had received regular performance reviews and attended staff meetings and events. An induction procedure was in place for implementation when new staff were employed to work at the practice. There was a clear management structure and staff told us they felt there was strong leadership at the practice.

Patients told us that the practice was always supportive and provided excellent care to meet the healthcare needs of patients. The practice had responded to feedback from patients and staff about ways that improvements could be made to the services offered that would be of benefit to both the practice and its patients.

Good



# 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

The practice offered personalised care to meet the needs of the older people within its population. They provided a range of enhanced services such as dementia and end of life care. Nationally reported data showed that the practice performed well against indicators relating to the care of older people. For example, the practice maintained a register of patients in need of palliative care and held weekly multidisciplinary care meetings where all patients on the palliative care register were discussed.

The practice was responsive to the needs of older patients. They offered home visits and rapid access appointments for those with complex healthcare needs. Patients 75 years of age and over were offered annual health reviews. The practice had recently employed a nurse care coordinator for two days per week to oversee and coordinate the care of patients 75 years of age and over. This service had been developed in recognition of the higher than average number of elderly and frail patients registered with the practice.

Good



### People with long term conditions

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. 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.

Good



### Families, children and young people

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered extended hours appointments for two mornings and two evenings a week for advanced booking. The practice also offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, sending secure messages to the practice, viewing medical record and updating patient details.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of attendances at the accident and emergency (A&E) department of the local hospital.

Good



# Summary of findings

## **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 on-line appointments and repeat prescription services, as well as a full range of health promotion and screening clinics that reflected the needs of this age group.

The practice offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, sending secure messages to the practice and updating patient details. The practice nurse had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions. The healthcare assistant led the smoking cessation clinic in the practice.

Good



## **People whose circumstances may make them vulnerable**

The practice held a register of patients living in vulnerable circumstances including people with a learning disability. The practice was committed to meeting the needs of vulnerable people and provided a caring and responsive service for them. Alerts were placed on these patients' records so that staff were aware they might need to be prioritised for appointments and offered additional attention such as longer appointments.

Good



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and dementia. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It confirmed that vulnerable patients were informed 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 both normal working hours and out-of-hours.

Good



# Summary of findings

## What people who use the service say

We reviewed 33 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all comments recorded were extremely positive. Patients commented that they were given excellent care by everyone at the practice and that staff were helpful, friendly and listened to them. Patients also commented that they could always see a GP when they needed to.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated March 2014 and a survey of patients undertaken by the

practice during 2014. The evidence from all these sources showed patients were satisfied with the service they received, felt that they were given enough time and that they were treated with care and concern.

The practice was average for its satisfaction scores on consultations with GPs and nurses. Data showed that 84% were satisfied with appointment times which was comparable with the national average of 80%; 78% described their experience of making an appointment as good compared with the national average of 75%; 80% would recommend this practice to someone new to the area which compared with national average of 79%.

# Bridge House Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Nurse specialist advisor.

## Background to Bridge House Medical Centre

Bridge House Medical Centre is located in Stratford upon Avon, South Warwickshire and provides primary medical services to patients. The practice covers Stratford upon Avon and villages of Hampton Lucy, Alderminster, Long Marston, Welford, Binton, Temple Grafton, Aston Cantlow and Wilmcote. The practice has seven GPs (four male and three female), one practice manager, nursing, administrative and reception staff. The practice is a training practice and has its own dispensary. There were 9695 patients registered with the practice at the time of the inspection.

The practice is open from 8am to 6pm Mondays to Fridays and is closed at weekends. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, book appointments and update personal details.

The practice makes more appointments available for working people. There is a varied rota of early morning appointments from 7am to 8am and some evenings 6.30pm until 7.30pm. All of these appointments have to be

booked in advance. During these extended hours the GPs do not have access to the support services that are usually available during normal working hours, such as practice nurses, administration and prescription requests.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as disease management clinics which includes asthma, diabetes, heart disease and well woman, child and travel immunisation clinics. The practice does not provide an out-of-hours service but has arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. If patients call the practice when it is closed an answerphone message gives the telephone number they should ring, depending on the circumstances. Information on the out-of-hours service is provided to patients.

Bridge House Medical Centre has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

## Why we carried out this inspection

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



# Detailed findings

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 our inspection of Bridge House Medical Centre we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted South Warwickshire Clinical Commissioning Group (CCG) and NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 5 March 2015. During our inspection we spoke with a range of staff that included four GPs, the practice manager, nursing and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with three patients who visited the practice during the inspection. We reviewed 33 comment cards where patients and members of the public shared their views and experiences of the practice.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

# 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, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time and could show evidence of a safe track record over the year.

Staff told us they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw where a recent incident had been reported in 2014 regarding a sharps bin and that action had been taken in response to this. We saw that significant events had been discussed at practice meetings which demonstrated the willingness by staff to report and record incidents.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda. We saw that minutes of the meetings were circulated to relevant staff by email and staff we spoke with confirmed this.

We saw that significant events were discussed at weekly practice meetings and effective action plans were put in place when required. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. For example, we saw that significant events and complaints had been discussed with staff from minutes of a meeting that took place on 9 February 2015. We saw that a patient had made a complaint about the way their concerns had been responded to by staff at the practice. The practice had also recorded this as a significant event. This had involved a number of staff at the practice at various stages. An investigation had been carried out learning from this had been identified should a similar issue occur in the future. The complaint had not been upheld. We also saw evidence that the actions identified for learning or improvement, as a result of individual significant events, had been

completed. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. GPs we spoke with confirmed this. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The lead GP confirmed that the significant events were also reviewed annually.

National patient safety alerts were shared by the practice nurse with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They told us alerts were discussed at practice meetings and recorded to ensure that all staff were aware of those that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training in safeguarding. Clinical staff had received appropriate training (advanced) in child protection. Staff we spoke with 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, properly record safeguarding concerns and knew how to contact the relevant agencies in both working hours and out of normal hours. We saw that contact details were easily accessible.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they knew their responsibilities to enable them to fulfil this role. All staff we spoke with told us who the lead was and knew who to speak to if they had any safeguarding concerns.

There was a chaperone policy available to all staff on the practice computer. We saw that a poster informing patients about the chaperone policy was displayed in the reception area. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Clinical and reception staff we spoke with told us they acted as chaperones when needed. Staff told us they had received chaperone training and they were clear about their responsibilities. This included, for example knowing where to stand when intimate examinations took place.

## Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments such as vulnerable patients or children who may be at risk of harm. GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors and social services.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy in place for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a potential refrigerator failure. Staff we spoke with understood and confirmed they followed the policy.

Processes were in place to check that 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.

The nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions such as those for shingles and nasal spray for flu. We saw evidence that nurses and the health care assistants had received appropriate training to administer vaccines.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. Where prescriptions were not signed before they were dispensed, staff confirmed that these were risk assessed and a process was followed to minimise the potential for risk. We saw that this process was working in practice.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. For example, we saw certificates that showed all dispensers held appropriate qualifications in pharmacy services. We also saw that staff carried out annual self-assessments as part of the quality monitoring for dispensary services.

### Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patients told us on the comment cards that they always found the practice to be clean and hygienic, and that they had no concerns about a risk of infection. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had recently appointed a lead for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that regular infection control audits were carried out. The most recent audit had been carried out February 2015. The infection control lead told us that three monthly audits were planned to enable follow up on actions identified. We saw that improvements identified for action were discussed at team meetings. Minutes of meetings confirmed that findings had been discussed.

An infection control policy and supporting procedures were available on the practice computer system for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff we spoke with described how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Guidance for staff was also clearly displayed in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

## Are services safe?

environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out regular checks in line with this policy to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw stickers indicating the last testing date were displayed. We saw that a schedule of testing was in place.

We saw records that confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during 2014.

### Staffing and recruitment

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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the completion of a risk assessment for non completion of DBS checks for non-clinical staff. We spoke with staff who confirmed that all the checks had been carried out prior to their employment.

The staff team were well established and most had worked at the practice for many years. We spoke with staff about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were told that the staff were flexible and covered for each other and would work additional hours if required. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

to the practice. These included regular checks of the environment, medicines management and 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 the practice manager was the identified health and safety representative.

The GPs and practice manager told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and contact was made to follow up on patients where they failed to attend.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. We saw evidence that basic life support training had been completed by all staff including reception staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and staff spoken with knew of their location. These included those for the treatment of cardiac arrest, a severe allergic reaction and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of telephone system, loss of computer system, GP sickness and loss of clinical supplies. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of local suppliers to contact in the event of failure, such as heating and water suppliers. We saw there was a procedure in place to protect

## Are services safe?

computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance; they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs that they completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. Shared records were in place to enable best practice guidance to be stored and shared by all staff. We saw copies of the guidance that had been circulated to clinical staff by email and minutes of practice meetings where new guidelines had been discussed and shared.

GPs at the practice each led in specialist clinical areas such as diabetes, palliative care, mental health, family planning and women's health. The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that they encouraged a culture in the practice of patients cared for and treated based on need. The practice took account of patients' age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Staff in the practice had key roles such as data input, scheduling clinical reviews, medicines management and infection prevention and control.

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 national performance measurement tool. Following the audits, the GPs shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice showed us five clinical audits that had been undertaken in the last two years. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw that audits had been carried out for the period April 2013 to March 2014 to determine whether the practice had followed alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). We saw that follow up audits had been completed which showed there had been a reduction in prescribing patterns for those medicines identified in the alerts.

Other examples included audits to identify the effectiveness of NHS health checks for patients registered with the practice. The results showed that 40% of patients had required some health care interventions and as a result of this the practice planned to increase uptake of the NHS health checks. They planned to use text alerts to remind patients to attend for these checks.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In most areas the practice had reached performance levels that were higher than the national average. For example, the number of patients with diabetes who had received their flu injection was 98% which compared with the national average of 93%.

The practice had investigated reasons why the data showed a low prevalence of patients diagnosed with dementia despite a higher than average elderly patient population registered with the practice. For example, data

# Are services effective?

(for example, treatment is effective)

showed that 77% of patients with dementia had received an annual care review which was lower than the national average of 84%. The practice had investigated this and as a result planned to carry out further screening of patients for dementia in other population groups at risk of dementia, such as patients over 75 years of age. The practice had however achieved 98% for their total QOF points compared with a national average of 94%.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system used at the practice flagged up relevant medicine alerts when the GP prescribed 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 these outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice 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.

## Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. We noted a good skill mix among the doctors who collectively had additional diplomas as medical education trainers, in occupational health, diabetes and family planning. All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

The dispensary team were responsible for the repeat prescribing service and dispensing medicines to patients who lived within the prescribing area of the practice.

Records showed that staff undertook annual appraisals and that learning needs had been identified. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, staff told us they were able to access on line training courses as well as vocational courses as these became available.

Bridge House Medical Centre was a training practice. A trainee GP would work at the practice for one year to gain experience in General Practice. Trainee GPs are qualified doctors who plan to enter General Practice. Bridge House also supported student doctors, who were attached to the surgery for six months as part of their ongoing training. Two of the GPs were trainers who supervised students and trainee GPs. Doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior or duty GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, vaccines, ear syringing, quit smoking programme and lifestyle advice. Those with extended roles as in monitoring patients with long-term conditions such as asthma, diabetes and heart disease 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 complex cases. 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 on 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 spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly (or sooner if required) to discuss the needs of complex patients, for example those with end of life care needs or children at risk of harm. These meetings were attended by health visitors and palliative care nurses. Decisions about care planning were documented in the patient's record. Staff told us this system worked well. GPs told us that they worked closely with the team to make sure patients' needs

# Are services effective?

(for example, treatment is effective)

were met and that important information was shared. Staff also told us that members of the community team such as health visitors and district nurses would join the daily morning meetings if there was information they wanted to share or had concerns they wanted to raise ahead of the more formal meetings.

The practice had recently employed a nurse care coordinator for two days per week to oversee and coordinate the care of patients 75 years of age and over. This service had been developed in recognition of the higher than average number of elderly and frail patients registered with the practice.

## Information sharing

The practice had a system to provide staff with the information they needed. The practice had an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. The GPs and staff told us how helpful they had found this software and continued to see its benefits. The practice manager informed us that the software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used 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 although not all referrals were made by the practice through Choose and Book. 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. GPs told us that the use of Choose and Book was low because patients preferred them to arrange appointments directly with consultants.

## Consent to care and treatment

We saw that the practice had a policy for documenting consent. We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe to us how they implemented it in their practice.

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They confirmed they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. 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. The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

## Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP identified and followed up all health concerns detected in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by promoting the benefits of childhood immunisations with parents or by carrying out opportunistic medicine reviews.

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 ensured that longer appointments were available for them when required.

The practice nurses we spoke with told us they carried out regular health checks of patients with range of long term conditions. They confirmed that meetings were held with the palliative care teams to ensure co-ordinated care was provided to patients that matched their needs and wishes. The practice also employed their own counsellor to support patients with their mental health. Staff told us and records confirmed that a GP and a nurse were trained in supporting patients with a learning disability. They told us they had access to the community learning disability team as needed to support patients with learning disability registered with the practice.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend by



## Are services effective? (for example, treatment is effective)

either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease. For example, last year's performance for patients with diabetes who had received the flu vaccine at 98% was higher than the national average of 93%.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations.

Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 years or over and patients with long term conditions were provided with a named GP.

Last year's performance for cervical smear uptake was 85%, which was slightly higher than the national average of 82%. There was a policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend. There was a named nurse responsible for following up patients who did not attend screening.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse. We saw that the practice had access to a database of support organisations that they were able to signpost patients to for further information.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction, taken from the national patient survey 2014 and complaints and compliments received by the practice. We also looked at the 33 Care Quality Commission (CQC) comment cards patients were invited to complete to provide us with feedback on the practice. The evidence from all these sources showed that patients were generally satisfied with how they were treated and confirmed that this was with respect, dignity and compassion.

We looked at each of the 33 comment cards completed by patients who told us what they thought about the practice. All comments were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They commented that staff were kind and sympathetic. We also spoke with three patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw the rooms had appropriate couches for examinations and curtains to maintain privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if patients wanted to speak to the receptionist or practice manager privately they would be taken to a private room.

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.

Observation of and discussions with staff showed that they were compassionate and treated patients in a sensitive

manner, particularly for those whose circumstances may make them vulnerable such as temporary residents or patients who were experiencing mental health issues. The practice had very few patients where English was not their first language. Staff told us that patients usually brought a relative with them but interpreters were available should they be required.

Staff told us they offered a chaperone service if patients preferred. We saw leaflets in the reception area and information on the practice website that confirmed this. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. When a chaperone had been offered information was recorded in patients' case notes and included a record where a chaperone had been declined.

There was information in the practice information leaflet and on the practice's website stating the practice's zero tolerance for abusive behaviour. Staff told us that occasions when they had had to refer to this to diffuse potentially difficult situations had been rare.

### 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. For example, data from the national patient survey 2014 showed 89% of practice respondents said the GPs were good at involving them in decisions about their care which compared slightly higher than the national average of 82%. The proportion of respondents to the GP patient survey who stated that they always or almost always saw or spoke with the GP they preferred was 42% compared with the national average of 37%.

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. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients commented that all clinical staff at the practice were particularly good when treating them and took the time to make sure they fully understood their treatment options.

## Are services caring?

We saw evidence of care plans and patient involvement in agreeing these. For example, each patient with a learning disability was given a longer appointment so that they could be given time to discuss their individual care plans. Other patients who were diagnosed with asthma also had individual care plans. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that patients were always encouraged to be involved in the decision making process. They told us that they always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative. The nurses told us that if they had concerns about a patient's ability to understand or consent to treatment, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. Patients were referred for blood tests to the local hospital. Clinics were held on Monday to Friday mornings 8.30am to 12.30pm and on Monday and Wednesday afternoons between 2pm and 3.30pm at Stratford Hospital. The practice Health Care Assistant (HCA) carried out more urgent blood tests in the surgery at the request of the GP or practice nurse.

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 that this service was available.

### **Patient/carer support to cope emotionally with care and treatment**

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, one patient wrote in the comment cards that they had received amazing support both in the swift diagnosis of their condition and in the subsequent treatment they had needed. They commented that staff were caring and supportive throughout. Comments from other patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations including how to get benefits advice. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they were given advice on how to find a support service for example CRUSE the national bereavement charity. One patient who had had a bereavement confirmed they had used this type of support and said they had found it helpful.

# 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 patients' 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 of patients in the way services were delivered. Staff told us the practice population consisted of a high number of older patients. For example, national patient data showed that the number of patients in the over 65 years of age population group at the practice was 22% compared with the national average of 17%. The population group of patients over 75 years of age at the practice was 11% compared with the national average of 8%.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and lung disease. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had a register of patients who had mental health concerns and we saw that annual health checks had been carried out. The practice had a palliative care register and regular multidisciplinary team meetings (MDTs) were held to discuss patient and their families care and support needs. We were told that the MDTs worked very well as a team to provide care for all patients. The district nursing team commented on the CQC comment cards that patients' interests and their well-being was always a priority, and that patients often gave positive comments

about the service they received from the practice. One of the GPs had previously worked in a hospice and told us they were able to share this knowledge and skills with the practice staff for the benefit of all their patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. For example, the PPG highlighted that patients had experienced difficulty with telephone access for appointments particularly around 8am. The practice carried out an audit to identify reasons for this. The audit demonstrated that most patients were given an appointment when they called but identified that the difficulty arose when patients had requested a specific appointment on a specific day. The online booking system had been suggested and following trials carried out by the PPG members, was introduced in September 2014 with positive responses.

### Tackling inequity and promoting equality

The practice proactively removed any barriers that some patients faced in accessing or using the service. Three female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice building was on two levels but arrangements were in place for GPs to see patients in ground floor consulting rooms where they had difficulty negotiating stairs. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning

# Are services responsive to people's needs?

(for example, to feedback?)

disability, or if a patient was also a carer so that additional appointment time could be made available. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it. Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person.

The practice had a policy in place and provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. We saw training records that confirmed this training had been completed or was planned. The practice had a GP equality and diversity lead and records showed they had completed training for this during 2014.

## Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information on the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open for surgery appointments from 8am to 6pm Monday to Friday. The practice was closed at weekends. The practice offered appointments outside their core service times to make more appointments available for working people. There was a varied rota of early morning appointments from 7am to 8am and some evenings 6.30pm until 7.30pm. These appointments were booked in advance with a receptionist.

Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP or nurse.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

## Listening and learning from concerns and complaints

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

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints pack available at the practice. The complaints pack could also be sent to patients should they request this.

Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans in place to address changes needed.

We saw that the practice had recorded all complaints and actions that had been taken to resolve each complaint as far as possible. We tracked three complaints and found these had been handled satisfactorily, in a timely way with learning identified where appropriate. For example, we saw a complaint had been made by a patient who was unhappy with how long they had waited for their appointment with a GP, who had been delayed. We saw evidence that the practice had responded to the patient's concerns and an apology had been made.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on. We saw that compliments received by the practice had been kept.

# Are services well-led?

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

## Our findings

### Vision and strategy

The practice sent us a copy of their statement of purpose prior to the inspection of the service. This told us that the purpose of the practice was to provide registered patients with high quality, safe health care within the framework of the NHS and to seek continuous improvement on the health status of the practice population overall. The practice aimed to achieve this by developing and maintaining a happy, caring multidisciplinary team which was responsive to patients health needs and which reflected the latest advances in Primary Health Care.

The practice aimed to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. GPs spoken with confirmed this. We spoke with eight members of staff and they all demonstrated that they understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with GPs who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and the practice manager were very supportive.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on their computer desktop within the practice. We looked at eight of these policies and saw that these had been reviewed and dated.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this

practice showed performance was generally above national standards. We found that QOF data had been formally discussed by the practice and we saw written records that showed how they had responded to maintain or improve outcomes for patients. We saw evidence that showed that QOF data had been reviewed and what actions, if any had been taken.

We saw that there had been full medicine reviews following a medicine alert or as part of the work the practice carried out with the prescribing support pharmacist. We saw that the practice had completed clinical audits to monitor quality and systems to identify where action should be taken to improve outcomes for patients. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance, to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. The practice had completed a number of clinical audits which included audits for minor surgery procedures and medicines prescribed to reduce heart failure.

The practice held monthly governance meetings. We looked at minutes from the last four meetings including the most recent meeting held on 23 February 2015. We found that performance, quality and risks had been discussed. The practice had arrangements in place for identifying, recording and managing risks. The practice manager showed us the risk file, which addressed some potential issues such as building maintenance and security. Staff showed us risk assessments that had been completed for risks such as needle stick injuries.

### Leadership, openness and transparency

At the start of the inspection the practice gave us a presentation on the services they provided. We observed how everyone interacted and supported each other during the practice presentation and this continued throughout the day. The atmosphere was friendly, open, supportive and welcoming.

There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. For example, there were clinical leads for patients with a learning disability, asthma, lung disease, diabetes, mental health, palliative care and

# Are services well-led?

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

safeguarding. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by everyone at the practice.

We found the practice to be open and transparent and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff confirmed that information was shared verbally and by email.

We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Staff told us that there was a positive, open culture and focus on quality at the practice. Staff said they had the opportunity and felt comfortable about raising any issues at team meetings. Staff gave us examples of when they had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and that the GP partners were visible and accessible. Staff told us that they enjoyed working at the practice and that everyone worked well together as a team. Staff told us that the GPs and practice manager were very supportive. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working. Two of the GPs told us that team work at the practice was their greatest strength.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example an induction policy, and the equal opportunities and anti-discrimination (employment) policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

Bridge House Medical Centre told us they were committed to continually improve their services by learning from and listening to their patients. The practice had an active Patient Participation Group (PPG) which had been established in 2012. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. We saw reports from the previous two years where the group had met and had discussed a range of topics. The group had a dedicated page on the practice website as well as a direct email address for patient feedback. They had also developed a virtual group who received email information and gave feedback via email to the group too.

The PPG produced a quarterly newsletter which could be viewed on the website or a paper copy made available at the surgery. We saw a copy of the latest newsletter produced by the PPG dated Spring 2015. The newsletter included information about the new hospital being developed in the town and an interview with the Development Director on how this would improve services for patients of Bridge House Surgery.

We saw a report from the PPG annual general meeting (AGM) held 14 January 2015 in which the 2014 patient questionnaire was discussed. The PPG reported that patient satisfaction with the practice was 89% which was higher than the national average of 85%.

The practice had gathered feedback from patients through comment cards, complaints and compliments received. The practice manager told us that they had made improvements to the appointment system by making online booking available to patients as a result of the patient feedback they had received. The online booking system was trialled by PPG members and became available to all patients in September 2014. The practice manager told us that this had been successful and within six months of operation 431 patients had registered for access to the system.

The practice had gathered feedback from staff through informal staff meetings and discussions. Minutes from meetings were kept and we were able to see evidence of a recent meeting between the practice manager and the GPs.

# Are services well-led?

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

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. They confirmed that they worked well together as a team and it felt more like being in a family than working with colleagues. However, if they had any concerns they confirmed that they would follow the whistleblowing policy which was available to all staff on their computers in the practice. Staff confirmed that they knew who to talk with in the event they had any concerns.

## **Management lead through learning and improvement**

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held in 9 February 2015. We saw that the details of the incident, who was involved, and action taken had been discussed. We saw from clinical meeting minutes for example, that medicine prescribing, complaints and SEs were regularly discussed. We noted that links to the relevant incidents had been recorded within the minutes that provided an accurate audit trail.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. They said that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with all staff at practice meetings.