Dr Mills and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Dr Mills & Partners on 17 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, responsive and effective services and outstanding for being well led. It was also good for providing services for older people, people with long term conditions, families, children and young people, people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice developed additional enhanced services and through joint working achieved Investors in People and the Quality Practice Award.

Summary of findings

We saw areas of outstanding practice including:

- The practice employed a person who worked with alcohol dependent patients and the success of this work was evident in patients' reduced dependency on alcohol and the proportion of patients with alcohol problems also reducing.

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles. The practice carried out regular appraisals and put in place personal development plans for staff.

We also saw evidence to confirm that the NICE guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care via the patient surveys. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available on the same day. The practice had adequate facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system.

Are services well-led?

Good

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. 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 using new technology, and it had a very active patient participation group (PPG).

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 the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Older people were allocated a named GP. They were contacted by the practice to inform them of their named GP who took lead responsibility for ensuring that they received appropriate care. GPs worked with relevant associated health and social care professionals to deliver a multi-disciplinary care package that met the needs of this patient group. The practice operated an 'Integrated Care Team' where any high risk patients could be referred for a multidisciplinary team approach to their care. This was effective where the patient needs were more social than clinical.

The doctors held a weekly ward round for the nursing and care homes where any patients who were given cause for concern could be seen. The visits included new patient reviews, medication reviews, Do Not Attempt Resuscitation (DNACPR) reviews and the practice could see patients that may have had recent emergency admissions. In addition the practice had a full six monthly review of each of the care homes in the area. This was a virtual review as not all the residents in the care homes were seen by the GPs.

Risk analysis took place and the practice held a register of patients who had unplanned admissions. This incorporated many of the elderly and nursing home patients who had an individual care plan and assigned GP. The care plans were reviewed on each contact with the patient and the entire register was reviewed every quarter at a practice meeting. Any patients that had an admission or A&E attendance would be contacted within three days and offered a follow up appointment if required.

The practice also offered a Seasonal Flu and Shingles vaccination for its eligible elderly patients.

People with long term conditions

Good

The practice is rated as good for the care of 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.

Patients with long term conditions were monitored via a recall system where they were offered annual or more frequent reviews where appropriate.

The practice had named GP leads for each chronic disease area. The nursing team were trained to support the main areas relevant to the patients and they had access to a set of protocols for each of these areas which were overseen by one of the GPs.

There was a high prevalence of diabetes within the practice population. The staff had been proactive in meeting the needs of these patients and the practice had achieved high standards across all nine areas of the Bradford Beating Diabetes programme in comparison to other practices. Two of the GPs and a practice nurse had been trained to Level 2 standard. A member of the administration team had special responsibility to oversee patient recalls and booking of appointments which had led to a very low DNA rate compared to other practices in the area.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice offered targeted and specialist clinics and appointments to try and capture this patient groups needs. There were set 'Mum & Baby' clinics which were run alongside the Health Visitors. These included eight week checks. There were also vaccinations and immunisations available with the nurses and the practice remained high achievers.

Summary of findings

The practice population had been an area of high teenage pregnancies and poor sexual health for a number of years. The practice offered a full range of contraception and sexual health screening. Bradford was one of the only areas to see improvements in this statistic.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people including those recently retired and students. The needs of this group had been identified and the practice had made adjustments to its services 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 which reflected the needs for this age group.

Working age people traditionally had difficulty with access to appointments therefore the practice provided early morning doctors, nurse and phlebotomy appointments and some late night GP appointments. The practice had also introduced some lunch time phlebotomy appointments. In addition to this they offered on-line booking of appointments and prescription request to make it easier for working patients to contact the practice.

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. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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.

All members of staff received training around safeguarding of children and vulnerable adults. The safeguarding lead was identified and available to talk to about issues that arise.

The practice had a social worker working with them who they could refer to and they was able to offer a range of supporting services to

Summary of findings

the more vulnerable patients. In addition the practice had an alcohol worker and they were currently seeking a benefits worker. The practice also had access to the 'Bridge and Ripple' teams who supported patients with substance abuse.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice was proactive in identifying and supporting patients with poor mental health. The practice participated in the Dementia Identification Scheme and had achieved a diagnosis rate of 74.94%. The practice actively supported patients through the Gateway Worker and the Primary Care Mental Health Team.

Summary of findings

What people who use the service say

We received 20 CQC comment cards and spoke with five patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The patients were complimentary about the care provided by the staff, their overall friendliness and behaviour of all staff. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and that they were given a professional and efficient service. They told us that their long term health conditions were monitored and they felt well supported.

Patients reported that they felt that all the staff treated them with dignity and respect and told us that the staff listened to them and were well informed.

Patients said the practice was very supportive and felt that their views were valued by staff. On the whole they were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients told us that the practice was always clean and tidy.

Findings from the 2014 National GP Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice.

Dr Mills and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager).

Background to Dr Mills and Partners

Dr Mills and Partners Highfield Health Centre is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Tong area of Bradford. The practice has six GPs, a management team, practice nurses and healthcare assistants, finance staff, administrative staff and cleaners.

The practice is open 8am to 6pm on Monday to Friday with a Wednesday opening of 7am to 7:15pm. When the practice is closed patients accessed the out of hours NHS 111 service.

The practice is part of NHS Bradford District CCG. It is responsible for providing primary care services to 7,300 patients. The practice is meeting the needs of an increasingly young patient list size that is generally comprised of an equal number of women and men.

Why we carried out this inspection

Dr Mills and Partners Highfield Health Centre was part of a random sample of practices selected in the Bradford District CCG area as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

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 in accordance with the Care Act 2014

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews and via comment cards completed by patients of the practice in the two weeks prior to the inspection visit. We spoke with GPs, the practice manager, assistant practice manager, clinical nurses, health care practitioners, administrative staff, finance lead and receptionists.

We observed how staff treated patients visiting and phoning the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

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, reported incidents, national patient safety alerts as well as comments received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Staff who identified an incident could talk to the practice manager or a GP and there was a reporting form to record this information. Incidents were prioritised so that urgent action could be taken if required, otherwise they were discussed at a monthly meeting where minutes were kept and actions managed. We saw there was an issues log kept for matters such as delayed discharge summaries and these were relayed via the Clinical Commissioning Group (CCG) monthly meeting.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings. An example was a 'Walk-in Centre' discussion which was considered and addressed as a result of a number of complaints from patients who were unhappy about access to appointments.

The practice had monthly opportunities to discuss and learn from significant events which could be reported by any member of the team via the clinical IT system. A case load/task group met to record and manage significant events and this was reviewed at a team meeting each month. There were also reporting systems for any safety issues or events, complaints and safeguarding issues.

All incidents were reviewed and there were weekly management meetings where any matters requiring immediate action could be dealt with. Investigations and meetings were documented with learning points and actions being passed to relevant parties. As a result of this learning appropriate new policies and procedures were introduced and stored on the practice intranet.

Notifications of changes to policies were discussed in group meetings or via a notification tool within the clinical IT system.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of the medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had named GPs and nurses appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A GP and practice nurse had attended level three childrens safeguarding training and they followed the local child protection protocols. There was a monthly meeting that considered safeguarding incidents with local social services teams. The practice manager was scheduling all the remaining GPs to complete the level 3 training over the next couple of months.

Chaperone training had been undertaken by all administration staff, including receptionists. The staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Good

Are services safe?

Safe procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all roles and responsibilities had been completed to determine the need for a criminal record check. Criminal record checks of staff employed within the practice, were repeated at three year intervals.

Staff members were encouraged to report any issues whether it was a health & safety matter or a patient safety/ safeguarding problem. Annual training was available in safeguarding via the safeguarding lead as well as on-line training. In addition the safeguarding protocol was available in hard copy and on the practice intranet. Basic health & safety training was given along with fire training each year and the practice encouraged team members to become wardens so that knowledge and responsibility was shared.

As a training practice they had a strong focus on providing access to training for all staff and they had a fixed annual schedule to cover core needs such as information governance, resuscitation and infection control training.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Patients were routinely informed of common potential side effects at the time of starting a course of medication. The IT system allowed for 'on screen' messages which showed side effect alerts and these were discussed with the patient. For example, patients were also reassured of rarity of side effects; for example for acute courses of steroid creams.

All team members are aware of the importance of care when dealing with patient medication. The practice had its own prescribing and repeat prescribing protocols which covered medication review, review date evaluation, home visits, hospital discharge, specials, shared care drugs and generic prescribing. The issue and collection of prescriptions was recorded on the clinical system.

The practice was fortunate to have experienced administration staff that kept a close eye on the issue of prescriptions in order to effectively deliver this service. All staff had a training session where they looked at in detail the step by step process of the issuing of prescriptions to ensure they had a safe and secure system in place.

Cleanliness and infection control

We observed the premises to be 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.

The practice had a nurse lead for infection control who 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 and thereafter had annual updates. We saw evidence the lead nurse had carried out audits for the last year and that any improvements identified for action were completed on time. We saw copies of a completed audit visit report with a score of 94.12%.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons 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.

Hand hygiene techniques guidance was displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

The Business Manager worked closely with Bradford District Care Trust to monitor the house keeping services for the practice. Standards were discussed and monitoring systems had been put in place. The senior house keeper helped the Business Manager monitor cleaning processes and waste disposal on a room by room basis. Any breaches were reported and dealt with immediately. An example where this has greatly assisted is with the registrar trainees. A gap in the induction process was identified and waste

disposal had been introduced to their induction process. The practice nurses lead on infection control and audit on a quarterly basis identifying any issues. The practice also had an independent external audit conducted by Public Health who also performed the annual training. This includes hand hygiene and prevention of health-care associated infection.

Equipment

Staff we spoke with told us they had sufficient 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 displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example ophthalmoscopes, otoscopes, digital blood pressure monitor and the vaccine fridge thermometers.

The practice was located in a purpose built health centre with maintenance contract in place with Bradford District Care Trust so that any building and maintenance issues could be dealt with swiftly. There were some additional services e.g. grounds maintenance and gritting that were provided by external agencies.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with the appropriate professional body and criminal records checks via 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.

Staff told us about the arrangements for planning and monitoring the number of staff 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.

The safety of the team was of paramount importance to the practice. They therefore operated within set staffing levels at all times of the day with importance being placed on no lone working. Absence requests were made in writing and discussed at weekly meetings.

Staffing levels were constantly reviewed and the use of patient and patient group feedback was used to help assess this.

Monthly rota meetings took place to ensure they had enough GP cover and they had an agreed staffing level of no more than two GPs being absent at a time. Extra consideration was placed on availability of appointments after bank holidays and practice shut downs though the introduction of the walk in clinic meant that they now had the ability to provide guaranteed appointments.

Absence was mainly covered in-house but the practice maintained a bank of preferred locums including Advanced Nurse Practitioners which helped cover any unforeseen short term absence.

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 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.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

The practice had CCTV with clear and visible signage in the care park explaining that recording of the premises was taking place to maintain safety for all staff and visitors to the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator which was used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment and how to use it and records

Good

Are services safe?

we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

The practice had a comprehensive business continuity plan specifying the action to be taken in relation to a range of potential emergencies that could impact on the daily operation of the practice. Risks identified included incapacity of the GP partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to. For example, contact details of the company responsible for servicing the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with one of the GPs who told us that they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as hypertension.

The GPs told us they lead in specialist clinical areas such as diabetes, hypertension and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the prescribing of medication. Our review of the clinical meeting minutes confirmed that this happened.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that 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.

The practice provided effective and patient focussed care to its patients which was reflected in its achievements and outcomes. Every month they had a protected learning time development session where current guidance and best practice was discussed and adopted into practice protocols. The practice also attended Clinical Commissioning Group (CCG) training sessions and meetings where best practice and current guidelines were discussed and participated in the use of current pathways and referral processes which were accessible via the practice clinical IT system.

The clinical system gave the practice access to chronic disease templates and care plans. These were checked via the IT system clinical reports and a robust recall process was in place. The practice had very low numbers in exempting patients and the whole team was proactive in contacting up patients who may have missed a recall appointment. QOF was monitored to identify patients who had missed or were due checks.

The practice had used a risk stratification tool for a number of years to help identify patients that required proactive care. The patients were reviewed on a monthly basis by two GPs and an appropriate care plan was put in place or they were referred to the Integrated Care Team if they need further input.

Assessment of practice data took place along with routine audits. The practice had access to the 'Primary Care Web Tool' and locally provided statistics from the CCG like the diabetes nine point care processes and other key performance indicators. The practice were able to benchmark themselves with local practices to help judge their performance. There was a high achieving culture with the practice and this was reflected in the practice's performance when compared to other practices in the CCG area.

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 assistant practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

The practice used information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, all of patients with asthma had an annual medication review, and the practice met all the

Good

Are services effective?

(for example, treatment is effective)

minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT 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 that the GPs had oversight and a good understanding of best treatment for each patient's needs.

We were told about how the practice provided end of life care. The practice worked to the Gold Standard Framework and multi-disciplinary meetings were held regularly.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Staff we spoke with told us that newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and we saw that this covered areas such as safeguarding, health and safety, fire and first aid.

Staff had received an appraisal every year and the practice manager confirmed to us that all staff would receive an appraisal yearly. Staff told us they were able to discuss any issues or training needs with their manager.

Staff told us that they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multi-disciplinary training and the open supportive culture were evident at this practice. We saw evidence of staff undertaking additional training in mental health.

Each year learning needs were assessed for the whole team and continuing professional development (CPD) was encouraged. The administration team had periodic assessments with 'test' patients to ensure that the clinical system was used accurately and appropriately. This was the practices own monitoring system as they did not find training needs analysis forms to be effective. Further views of the staff were sought via annual appraisals.

Protected time was put into the rota to help de-brief the trainees and any new clinical members of staff. Mentors were also allocated though the whole team and was supportive. New members of staff also received an induction pack which covered practice policies, referrals and other essential guidance.

There was also allocated training time with experienced members of staff for key areas. There was an annual practice closure timetable which covered core training and feedback was sought from team members to provide other training topics they would find useful.

Any out of hours care or care by other services was monitored via the clinical system. Where there had been out of hours care or hospital attendance a GP was allocated to review the data and see if any further follow up was required. Where the patient was on the unplanned admissions register they were automatically called and offered an appointment or access to a clinician.

Referral processes were constantly changing and therefore there were electronic updates and training was available for the doctors from the administration and secretarial team. Essential patient data was recorded on the practice clinical system and appropriate care plans were updated.

Staff were fully supported and could seek guidance from the lead GP or senior members of the team when there were issues of consent and competency for both adults and children whether it was relating to data sharing or providing treatment.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice had clear arrangements in place for referrals to other services. Patients told us that they were given a choice of which hospital they would like to be referred to. It was the GPs responsibility to follow up on the referrals.

Staff worked together to assess and plan on-going care and treatment in a timely way when patients were discharged from hospital. We spoke with the practice manager who told us that discharge letters were scanned on to the patient's record (about half of the hospital letters were received electronically), which enabled the practice to have an effective means of ensuring continuity of care and treatment of those patients discharged from hospital. We were told that these were scanned onto the patients' records so a clear history could be kept and an effective plan made.

The practice had systems in place for managing blood results and recording information from other health care providers including discharge letters. The GP viewed all of the blood results and took action where needed.

The practice worked closely with other social and health care providers. The practice had a weekly session provided by a benefits advisor to which the practice could directly refer patients.

The practice manager was involved with a group of GP practices which met once a quarter to discuss and manage common themes in practices in the area to enable the practices to work more effectively.

Information sharing

Systems were in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital. The practice manager reported that this system was easy to use.

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 on the system, and commented positively about its safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice followed Gold Standards for patients nearing the end of their lives and regular palliative meetings were held within the practice which included the District Nursing Team and the MacMillan Nurse.

Access was available to the NHS Health checks (156 have been completed so far this year) and the practice fully support patients in their life style choices to help prevent long term condition. The practice also used 'fit notes' and referred where appropriate.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

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 agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances required it. While talking with staff they 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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

The practice provided a named GP for patients aged 75 and over. The practice had written to all patients aged 75 and over, informing them of their named GP.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

It was practice policy to offer a health check with the health care assistant / practice nurse 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 a culture among the GPs to use their

Good

Are services effective?

(for example, treatment is effective)

contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering diabetes checks to patients and offering smoking cessation advice to smokers.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area. The practice had also displayed useful information for patients which was situated in the reception and waiting areas. Information on the PPG, NHS, dementia support memory club and Ebola. This provided a good service for patients to seek health promotion information and literature.

Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home.

The nurse we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD), cervical screening and travel vaccination appointments.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey tool and feedback from patients undertaken by the practice via the Patient Participation Group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that they were treated with compassion, dignity and respect. For example, data from the GP patient survey showed the practice was rated 90% for patients where they were able to get an appointment that was convenient. The practice was also above average for the CCG, the practice scored 95% for its satisfaction scores on 'had confidence and trust in the last nurse they saw or spoke to'.

The practice was focussed on meeting the needs of patients. The practice had consistently had positive feedback from patients about the level of care provided. In a recent GP survey they had a 95.6% good patient experience rating compared to 85.7% nationally and 84.9% locally. The practice had scored consistently above national average in the time a clinician spends with a patient, their rating of time spent listening to a patient and also explaining tests and results to a patient. The practice also scored higher than the national average in treating patients with care and concern (Doctors 85.9% compared to 83% and Nurses 81.5% compared to 78.7%). This is also reflected in 86.6% of patients saying they would recommend the practice compared to 78.7% nationally.

However a consequence of the time the practice spent with patients had been that they have not done quite as well with waiting times and availability of appointments. This has been an area the practice has had most complaints about. To try and remedy this the practice had introduced a walk in clinic twice a week where they guaranteed that if a patient turns up between 1.30-2.30pm they will be seen.

The reception team was also rated highly in being helpful 87.2% compared to 86% locally. They were dedicated in their approach to patient care. The reception and waiting areas were not ideal for a practice of this size. Patient confidentiality was an issue in the waiting area but when patients wished to speak confidentially the practice offered to take them to a private room to discuss their needs or concerns. There was signage up to indicate this was available and the reception team were aware to offer this service.

Where patients had any impairments or disabilities their patient records included an alert so that the staff team could adapt to their needs and where patients had carers they were included in their care and treatment if the patient was in agreement. The practice also offered support for the carers through the Integrated Care Team and various voluntary sector organisations. Where necessary care plans were put in place to assist patients in managing their own health and wellbeing. The care plans were discussed and agreed with the patients.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained 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 observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was shielded by partitions which helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed issues had been discussed.

Good

Are services caring?

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 GP patient survey showed 92% of practice respondents said the GP listened to patients and 88% felt the GP was good at explaining treatment and results. Both these results were similar to other practices in this Clinical Commissioning Group (CCG) area and nationally.

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 service was available.

Patient/carer support to cope emotionally with care and treatment

The national GP survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. 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.

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 people'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.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice had committed a lot of time and effort into responding to fluctuations of demand.

There had been very little turnover of staff during the eight years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local nursing and residential care homes by a named GP. The result of this was seen in the reduced need for unplanned call-outs and reductions in unplanned admissions to hospital. The practice had achieved and implemented the gold standard framework for end of life care.

The practice had tried to actively engage with its patients via surveys and its patient group. The practice had targeted specific questions around the services patients would like to be provided and they also reviewed significant need within chronic disease areas before introducing any new service.

Analysis of data on hospital and A&E admissions, outpatient referrals (elective & non elective), top speciality areas and risk analysis all helped inform the practice's decision making processes. In addition to this they worked with the CCG on locally identified areas of need and enhanced services such as anticoagulation and diabetes.

By using surveys within practice and also electronically via the website they were able to gather information from harder to reach groups who are not able to attend practice patient forums.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to translation services and GPs who spoke other languages.

The practice provided equality and diversity training to its staff. Staff we spoke with confirmed that they had read the 'Patient Dignity Policy' and that 'Equality & Diversity Policy' was discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities. This included access for wheel chair users.

Access to the service

Appointments were available from 8am to 6pm on weekdays with extended opening on Wednesdays from 7am to 7:15pm. Multiple pre-bookable appointments were available up to two weeks in advance. There was a practice guarantee that no one was turned away.

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

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were generally happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice.

Following feedback about the difficulty of access to appointments from patients and further to discussions with the patients participation group the practice introduced a walk in clinic where they guaranteed that patients would be seen. These were on a Tuesday and Thursday which meant they had rapid access to an appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice utilised a telephone based system to organise appointments. The practice also catered for walk-in cases and people who did not have access to a telephone. Reception staff were the first point of contact for patients. They were trained to take demographic data and brief medical details. Patients were offered a routine appointment, a same day or an urgent appointment.

Patients could book directly into nurse appointments or they were contacted by reception to book appointments for chronic disease management. The nurses had recently started to provide a telephone follow up service for chronic disease management which had proved popular with patients.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment; they walked into the practice and were seen by a GP that afternoon.

The practice was situated on the ground of the building with all of services for patients on the ground floor

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Following feedback from patients and carers the practice had developed more specific clinics and clinic times for health assessments. For example health checks for patient with learning disabilities were held at set times when they could invite in support workers from Carers Resource and also specialist nurses from the Learning Disability Team. These had proved to be popular for the carers who did not often get the chance to speak with support groups.

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 saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager responded to complaints offering the patient the option to come in and discuss the issue. The manager contacted the GP concerned and the item was discussed at the weekly Friday team meeting. We looked at the summary of complaints for the last year which highlighted the category of the complaint, summary of the complaint, the outcome and the learning outcomes for the practice.

Where there had been a patient complaint they were informed of the outcome of any investigation and would be invited in for a meeting if required. Where it was found that the practice had not reached appropriate standards or that they were in error then a written or face to face apology would be given along with the opportunity for the patient to escalate the complaint should they so wish.

Any constructive feedback from suggestions or complaints was also taken into consideration. Patients had access to a suggestion box in the waiting area as well as on-line. Complaints could be made in writing or orally to the practice. A leaflet was available to explain this to patients or members of the reception team could explain it in private to the patient. Complaints were recorded by the Business Manager and reviewed with the partners. Learning points were fed back to the team with any required changes being implemented. The complainant was apprised of any outcomes along with an apology where appropriate.

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 were told details of the vision and practice values were part of the practice's business plan. These values were at the heart of the staff we spoke with.

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The staff team understood and shared the vision for the practice and the GP partners had agreed the strategic approach of the business, we saw evidence of documented planning which supported their decision making.

The practice believed that they were a caring practice that promoted equality throughout its services and provided a positive experience for all their patients. The aim and objectives were to provide efficient, safe and appropriate services for all the patients in their core and specialist areas of work through the core values that are shared among the partners and staff.

The Practice had spread its philosophy throughout the team through shared learning in its team sessions and in particular through shared working to achieve set goals over the last seven years.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain and improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The deputy practice manager showed us their risk log which addressed a wide range of potential issues. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of legionella bacteria. All risk assessments had been recently reviewed and updated.

The practice had recruited appropriately to put in place a progressive team to take it forward and it still had some of the founding partners to help guide and advise the new. The team had embraced change and actively sought to improve all aspects of the practice. In the last six years it had changed to a more advanced clinical system, moved location and re-developed the premises, developed additional enhanced services and through joint working achieved Investors in People and the Quality Practice Award.

In particular the work that went into the Quality Practice Award involved the whole team working together and developing an understanding of how each part of the service fits together to provide better care for its patients.

All staff were well trained and worked within their competencies. There was an excellent support network within the practice. Job descriptions were in place along with clear policies and procedures so everyone was able to work safely and provide accurate data.

The practice reflected monthly in group meetings on events and learning was documented and shared throughout the practice. Clinical data was analysed to assist patient care and regular audits took place and were kept in an audit file. As a training practice they regularly undertook audits with the Registrars and these were fed back at practice meetings. In addition they had an attached pharmacist who assists with performance data and other audit work.

Weekly management meetings took place with the Partners and the Business Manager, as well as the administration management team. These meetings were used to feedback on issues in terms of staffing, workloads and any safety issues.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with

Are services well-led?

Good

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

members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

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.

Staff told us they felt very well supported and knew who to go to in the practice with any concerns. The GPs fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information. Staff told us that there was an open and transparent culture within the practice. They had the opportunity to contribute to the agenda of team meetings, to raise issues within team meetings and on a more informal basis and felt well supported in doing so.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

The practice has a strong management team who are always proactive in seeking solutions to providing good care. There were numerous routes to identifying issues and feeding back to the management team via team leaders and fixed meetings and agendas. Many of the practice planned closures focussed on team building and appreciating the roles of other members of the team. Ideas were actively encouraged from all members of staff to find solutions to providing better care to our patients.

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

The practice had gathered feedback from patients through annual patient surveys, comment cards, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown a report on comments from patients.

The practice has an established patient participation group (PPG) who contributed and fedback customer satisfaction. The practice had found these comments an extremely useful reflection tool for helping to improve customer service. Currently there were eight members.

The practice manager was working with the PPG to have broader representatives from various population groups; including people from ethnic backgrounds. A GP always attended every PPG meeting. The PPG met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

Recent improvements made to the practice as a direct result of the PPG include replacement of the waiting room chairs.

The practice had gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw minutes of a meeting where improvements were discussed and an action was agreed by all staff.

The practice had a whistle blowing policy which was available to all staff 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 looked at four files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice offered all GPs and nurses protected time to develop their skills and competencies. Staff who we spoke with confirmed this protected time was available. Staff also told us they were actively encouraged to take study time.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes.

Are services well-led?

Good

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

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings, GP partner meetings and monthly practice staff meetings.

Due to the increased changes that were taking place time was a concern to the practice. Historically this had been one of the lower funded practices in Bradford but had one of the higher deprivation ratings with a score of 48.5 on the index of multiple deprivation which compared to a national average of 26.6 in England. This has meant that the practice has not been able to afford the staffing levels of some other practices though the patient needs were high.

The practice had to work carefully to balance its workloads and fit in training, protected learning times and meetings so as not to impact on appointment times which have to be the priority. The practice used the experience of its staff to inform its decision making and also sought the views of its service users and PPG via meetings and surveys.

The practice was currently trying to expand the information base and make it more inclusive by looking at how they contacted the hard to reach groups. They were using the PPG to assist with this. The practice also worked alongside three other local practices to improve health care locally and share experiences and knowledge. The Business Manager also worked within a larger group of managers in Bradford and arranged joint learning and support.