Bridgegate Surgery

Quality Report

Retford Primary Care Centre
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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 carried out an announced comprehensive inspection at Bridgegate Surgery on 10 March 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was available and easy to understand.
- Patients said they found the appointment system very accessible.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

- The practice did not consistently monitor systems and processes for infection control and they had not ensured staff had completed training in this area.
- A planned clinical audit cycle was not used to monitor the effectiveness of the care and treatment provided to improve outcomes for patients.

Summary of findings

- Whilst the GPs and practice manager had a clear vison for the practice there was no business, financial or development plan available.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. 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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

The practice did not consistently monitor systems and processes for infection control and they had not ensured staff had completed training in this area.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training. The management team had identified improvements in monitoring; planning and recording training was required. There was evidence of appraisals and personal development plans for staff. Staff worked well with multidisciplinary teams.

A planned clinical audit cycle was not used to monitor the effectiveness of the care and treatment provided to improve outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Evidence from data and discussions with patients showed patients rated this practice highly in all aspects of their care. They said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population when developing service. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services

Summary of findings

where these were identified. Evidence from data and discussions with patients showed patients were highly satisfied with the appointments system in place. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available on the website andin the practice. The information was easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. Although the practice was going through significant changes it had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Whilst the GPs and practice manager had a clear vison for the practice there was no business, financial or development plan available.

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 outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP and the practice had a dedicated telephone number for these patients to speak to a health professional. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits. Regular visits to local nursing homes were also undertaken. Monthly multi-disciplinary meetings were held to review the care needs of older people. The practice worked closely with other health and social care organisations and ran a number of in-house clinics.

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 and monitored. Home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to monitor patient outcomes and to deliver a multidisciplinary package of care. The practice held a number of in-house clinics to support this group of patients such as, clinics for asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease.

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 who were at risk, Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with other agencies such as the health visitors and held a number of in-house health care clinics.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The services offered ensured appointments were accessible, flexible and offered continuity of care. Pre-bookable, telephone consultations and late evening appointments were all available to this group of patients.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. A number of clinics were also available in-house such as smoking cessation.

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 those with a learning disability. It offered annual reviews for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It signposted vulnerable patients to access various support groups and voluntary organisations. Information leaflets were available in easy read formats. Staff had access to tools such as a translation picture book to assist communication with patients where English was not their first language. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and had good links with counselling services.

Summary of findings

What people who use the service say

We received 29 CQC patient comment cards and spoke with two patients on the day of our visit.

Patients told us they were very satisfied with the service they received. They described the service as exceptional, wonderful, excellent, responsive and efficient. All who commented described the staff as being caring, helpful and respectful.

The patients were complimentary about the care provided by the clinical staff. They told us the staff listened to them, explained treatments to them and involved them in decisions about their care. They said they were treated with courtesy and compassion. Patients said they were supported with their long term health conditions.

Patients told us all the staff treated them with dignity and respect

Patients told us appointments were available and they didn't have to wait too long to be seen after their appointment time.

Patients said the practice was always clean and tidy.

There were some concerns from patients about whether the quality of the service would be affected following the planned merger with a neighbouring practice.

The latest GP survey results published on the 8 January 2015 showed 265 surveys were sent out in 2014 and 126 patients responded. The results showed the practice scored better than the national average in a number of areas and 91% rated their overall experience of this surgery as very (64%) or fairly good.

Areas for improvement

Action the service SHOULD take to improve

The practice does not consistently monitor systems and processes for infection control and they had not ensured staff had completed training in this area.

A planned clinical audit cycle was not used to monitor the effectiveness of the care and treatment provided to improve outcomes for patients.

Review arrangements for business, financial and development plans for the practice.

Bridgegate Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

We also worked closely with the CQC inspection team undertaking the inspection at the neighbouring practice. This team was led by a CQC Lead Inspector and also included a GP specialist advisor.

Bridgegate and the neighbouring practice planned to merge in the future and at the time of our inspection shared some administrative and managerial functions.

Background to Bridgegate Surgery

Bridgegate Surgery is situated within a purpose built health centre in Retford.

The practice provides General Medical Services (GMS) for 7300 patients.

There are four GP partners, three male and one female plus one female salaried GP. There are three practice nurses, two health care support workers and a phlebotomist.

This practice is to merge with a neighbouring practice which shares the same building and preparations for the merger were underway. Some administration functions were being shared at the time of the inspection and the managers and administration team were, or had recently, undergone changes to their role.

The surgery is open from 8.30am to 6.00pm on week days. On Wednesday and Thursday the closing times are variable as each GP provides some evening appointments, on a rota basis, until 8.10pm. These appointments must be pre-booked and are primarily for patients who find it difficult to attend during normal surgery hours.

Out of hours services are provided by the practice between 8.00am-8.30am and between 6.00pm- 6.30pm, Monday to Friday; public holidays are also covered. In all other instances services are provided by NHS 111or 999 services. A NHS walk-in centre is also available at Westwood 8-8 Primary Care Centre located on Pelham Street, Worksop, S80 2TR.

The practice is registered to provide the following regulated activities; family planning, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

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

Please note 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 the time.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Bassetlaw Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 10 March 2015. During our visit we spoke with a range of staff including three GPs, a registrar, the practice manager, assistant practice manager and assistant manager for information technology and finance. We spoke with two patients who used the practice including a member of the patient participation group (PPG).

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 29 CQC patient comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

We worked closely with the CQC inspection team undertaking the inspection at the neighbouring practice due to the shared functions and management arrangements at the two practices.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included, reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients. The practice had processes in place to ensure incidents would be reported, recorded and investigated. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw records which showed the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff we spoke with knew how to raise issues for discussion at the practice meetings.

The assistant manager showed us the system they used to manage and monitor incidents. We looked at incidents records and saw they were completed in a comprehensive and timely manner. Records of action taken were also maintained. A log of significant events, outcomes and actions taken was available. Significant events were reviewed during a weekly multidisciplinary meeting and non-clinical issues were discussed at the practice meetings. There was evidence the practice had learned from these events and the findings were shared with relevant staff. The log showed no particular patterns or trends for concern. The records showed information was shared with colleagues and other non-clinical staff as appropriate and learning had taken place. Actions were taken to minimise the risk of reoccurrence. Where there were issues relating to partner agencies such as the hospital, community nurses or pharmacies these issues were raised with the agency appropriately.

Where patients had been affected by something that had gone wrong we saw, where applicable, action had been taken to protect patient's health and welfare and an apology was given.

Safety alerts were received by the practice manager and saved electronically. These were shared with staff and discussed at practice meetings. Any further action taken was recorded.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at records which showed staff had received training in safeguarding both adults and children.

It is recommended in the Intercollegiate Guideline (ICG) "Safeguarding Children and Young People: roles and competences for health care staff" (2014) clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should undertake level 3 training in safeguarding children. There was evidence to show the GP who took the safeguarding lead role had completed this level of training. Two other records we saw for clinical staff showed they had completed level 2.

Staff accessed training via an electronic learning package and additional training was provided during their protected learning time. This training was also part of staff induction. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. Safeguarding policies and procedures and the contact details of relevant agencies were available and accessible for all staff. These had recently been updated and were being circulated to staff for them to read and sign. Policies and procedures included guidance to follow where child exploitation was suspected.

Staff told us safeguarding concerns were discussed at weekly clinical meetings. They also told us the practice held regular safeguarding meetings with other agencies, such as the health visitor, to discuss concerns and share information about children registered at the practice. Vulnerable adults who may be at risk were reviewed at the monthly multi-disciplinary meeting held by the practice.

There was a chaperone policy and procedure in place. Staff we spoke with had received training and had a good understanding of the chaperone procedures.

Good

Are services safe?

Medicines management

Medicines were kept in a secure storage area, which could only be accessed by clinical staff. We saw dedicated fridges were used to store medicines which required refrigeration. Logs of the daily checks of the temperature of fridges had been maintained. We saw these were within the recommended temperature ranges for the medicines stored. Policies and procedures were in place and staff had an understanding of the action to take in the event of the fridge temperatures being outside of the recommended ranges. There had been two incidents reported relating to the fridge temperatures being out of range. These were reported as significant events. The records showed correct action had been taken in response to management of these incidents. Equipment had been replaced to minimise the risk of further occurrence.

We saw medicines for use in emergencies were accessible to staff. We saw these medicines were in date and were routinely checked.

Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. Repeat prescriptions were signed by a GP and checks were made to ensure the correct person was given the prescription. There were procedures in place for GP reviews to monitor patients on long term medicine therapy.

Any changes in guidance about medicines were communicated to clinical staff by the practice manager. The information was then discussed with staff at meetings and further action taken if necessary. For example, in response to new guidance about a medicine we saw this had been discussed in a meeting. An audit of patients prescribed the medicines was completed to identify if any changes to patient prescriptions were required.

Cleanliness and infection control

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

An infection control audit had been completed by the infection control nurse from the local clinical commissioning group (CCG) in November 2013. This had identified some shortfalls. An action plan had not been developed but there was evidence some action had been taken to address the shortfalls. For example, detailed room and equipment cleaning schedules and a needle stick injury policy and procedure had been developed and implemented. Audit templates had been developed to monitor areas such as hand washing and use of sharps containers. However these had not been used and the infection control audit had not been revisited to check all shortfalls had been addressed. The infection control lead said these checks had not been implemented due to protected time not being identified for this role.

Records showed the lead for infection control and another member of staff had completed infection control training with the local CCG. Records were not clear as to when other staff had completed infection control training. Staff told us they had not attended recent infection control training. The assistant manager stated staff had access to this via eLearning but had not monitored this area to ensure completion of training. The new practice manager told us they were aware of the issues relating to training and plans were in place to provide more structure in this area following the merger.

An infection control policy and supporting procedures were available 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 were available for staff to use and staff were able to describe 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.

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.

A policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings) could not be found by the assistant practice manager. They told us the landlord was responsible for ensuring the water systems were checked. We saw a monthly compliance report was provided to the practice by the landlord and this showed the water systems had been tested in March 2015. In addition, we saw records which confirmed the practice also carried out regular checks to reduce the risk of infection to staff and patients. However, the shower head in one practice nurse room was scheduled for cleaning every

month but records indicated this had not been completed since November 2014. The practice nurse told us she would ensure this was completed and would monitor this in future.

Equipment

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

Staff we spoke with were aware of how to access equipment in an emergency and we observed emergency equipment was easily accessible to staff.

Staffing and recruitment

The practice was merging with a neighbouring practice and shared some procedures and tasks in areas such as administration and human resources (HR).

The practice had recruitment policy and procedures. The documents identified the checks were required for recruitment of clinical and non-clinical staff and the process to be followed to obtain these checks. For example, it included the type of proof of identification required, number of references, checking registration with the appropriate professional body and the criteria for criminal records checks through the Disclosure and Barring Service (DBS). We saw relevant checks were in place in all the staff files we reviewed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave. They told us they rarely used locum GPs and used a buddy arrangement with the neighbouring practice to cover GP leave.

We saw there were changes in progress in relation to the organisational structure for administration and management staff due to the planned merger, this included centralising some functions. Staff felt well supported and had been informed of the changes. Staff across the two practices had the opportunity to meet together at joint practice meetings and the two merging practices had a recent staff away day to discuss the practice vision and values.

We received positive comments about the staff and patients told us they found all the staff to be caring and helpful.

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. The responsibility for risk management and maintenance of the building was shared with the landlord and other tenants. Staff had completed fire safety training and fire warden training was also provided.

Risks were assessed and actions to reduce and manage the risk were recorded. For example, we saw health and safety and fire risk assessments had been completed and action plans were in place. We saw from a recent action plan the fire evacuation chairs, used to assist patients to get down the stairs, had not been serviced and were, therefore, not fit for use. These were the responsibility of the landlord. The assistant manager could tell us how the evacuation plan would be managed without the use of the chairs. However the practice had not updated their evacuation procedure to take this issue into account.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. We saw emergency equipment was accessible to staff, this included access to oxygen and an automated external defibrillator.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable 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. This included contact numbers for services such as water, gas and electricity and included guidance for staff in the event of a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE), local commissioners and in-house protocols and templates. Guidance was accessible on the practice electronic records.

Clinical staff we spoke with told us they were well supported and said they shared information and felt able to ask colleagues for advice and support.

The data from the local clinical commissioning group (CCG) which related to the practice's performance for prescribing hypnotic medicines was better than similar practices and were within average levels in other prescribing areas. The practice carried out audits to monitor prescribing patterns to ensure best practice.

The GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. An audit of the practice performance in meeting this target had been completed and found the practice had had performed well and areas for improvement were documented.

Interviews with GPs confirmed the culture in the practice was the patient's clinical need was the basis for care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, child protection and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service. National data such as Quality and Outcomes Frame work (QOF) showed the practice performed well in all areas. The most recent data available to us showed the practice had achieved 97.4% of the available QOF points. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice met all the minimum standards for QOF in diabetes, asthma, COPD and mental health. They were above the national average for recording alcohol consumption for some groups of patients.

We saw information which related to prescribing data for the practice. These showed patterns of antibiotic, hypnotics, sedatives and anti-psychotics prescribed within the practice were within or better than expected levels.

The practice used a proactive care planning approach to minimise the risk of patients being admitted to hospital. Care plans were in place to minimise the risk of unplanned admissions for these patients and these were reviewed by named GPs every three months. Patients who had been admitted to hospital were contacted by the practice on discharge to review their needs. Patients with complex needs, patients receiving palliative care and unplanned admissions were reviewed at monthly multidisciplinary meetings. The practice held a number of in-house clinics to support patients with chronic disease such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. They had a recall system to ensure patients were regularly reviewed.

We found the practice did not use a planned clinical audit cycle in order to monitor the effectiveness of the care and treatment provided to improve outcomes for patients. A GP told us two clinical audits had been completed in the last twelve months and were completed as part of their GP validation process. We looked at two audits provided to us. One audit had been completed to review performance against the urgent referral standard and another related to the review the clinical effectiveness of clinical staff in relation to cervical smears. The audits identified areas of good practice and any areas for improvement.

Effective staffing

On discussion with the assistant manager and practice manager there was some confusion about who was recording, monitoring and planning training for staff. The assistant manager told us the records may not be up to date as they waited for staff to inform them when they had completed mandatory training via the practices eLearning system. We observed there was no process in place to actively follow this up. They also told us there was no

training plan in place. The management team told us they had identified monitoring, planning and recording training required some improvement and they had plans in place improve systems following the merger.

We saw staff had received induction training and this had included some mandatory training such as safeguarding and fire awareness training. We saw staff had completed some role specific training such as system training for managing patient records and chaperone training. The majority of staff were up to date with essential training courses such as annual basic life support, fire safety and safeguarding vulnerable adults and children. However, records showed, apart from two nurses, staff had not completed infection control training and staff we spoke with confirmed they had not had any recent training in this area.

GPs told us they were up to date with their continuing professional development requirements. (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 practice is a training practice and doctors who were training to be qualified as GPs offered extended appointments to patients and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

All staff undertook annual appraisals which identified learning needs from which action plans were documented.

Practice nurses and health care support workers were expected to perform defined duties and they were trained to fulfil these duties. Clinical staff told us they were well supported and said there were plenty of opportunities for clinical support and training. Health care support workers had the opportunity to expand their skills in order to offer additional services to patients. They had received training in areas such as injections and vaccines, dressings and spirometry.

Working with colleagues and other services

The practice worked with other service providers and held regular multi-disciplinary meetings to monitor patients at risk, review patients' needs and manage complex cases. We saw health professionals, which included health visitors and palliative care and community nurses, were invited and attended these meetings.

Nursing staff also attended link meetings for diabetes, tissue viability and immunisation. Information was disseminated to staff via regular practice meetings.

Procedures were in place to manage information from other services such as the hospital or out of hours' services. Staff were aware of their responsibilities when they processed discharge letters and test results. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff. New information technology (IT) systems had been implemented over the past 12 months to significantly improve these processes.

Information sharing

Improvements to the practice IT systems was undertaken, in part, to enable the planned merger of Bridgegate and the neighbouring practice. Staff told us it improved internal communication and integrated records and systems so information was more accessible. For example, they had introduced a direct link to the pathology laboratory for samples and requests. They told us this had made this process quicker and safer. Electronic prescribing was planned for May 2015.

The patient record system used in the practice and that used by the partner agencies, such as district nurses, was a shared system. Systems enabled transfer of information about patients care needs to out of hour's services.

Information about patients' needs was also shared, where required, at regular multidisciplinary meetings held in the practice. The purpose of these meetings was to discuss problems encountered by those patients who were vulnerable or had several long term conditions and to look at ways of improving service delivery and patient care and minimising hospital admissions.

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care and policies and procedures were also available electronically.

Good

Are services effective?

(for example, treatment is effective)

Regular staff meetings were held and we saw information relating to the management of the practice, impending changes and learning points from complaints, incidents and alerts were discussed.

Consent to care and treatment

We found GPs were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We did not see any evidence on the training log training in this area had been provided. However the clinical staff we spoke with understood the key parts of the legislation. They also demonstrated an understanding of the assessment procedures to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

The practice offered NHS Health Checks to all patients aged 40 to 75 years and annual reviews for those patients over 75 years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

The practice web site provided access to a wide range of patient information and links to other websites. For example, the NHS Choices web site where patients could access information such as healthy living advice for families and advice for people with long term conditions and minor illnesses. The pages on the practice web site could be easily translated into different languages. A range of health information leaflets were also displayed in the practice waiting area.

A wide range of clinics and services were available for patients within the practice. For example, cervical screening, family planning, hypertension clinic and smoking cessation advice. Services such as dressings, wound care, doppler testing and ear irrigation were also available. One GP also offered a service for carpel tunnel and trigger finger surgery.

The practice referred patients to other providers as required, such as, the 'Let's Talk Wellbeing' counselling service and Idle Valley Nature Park for activities aimed at patients with mental ill health.

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 national patient survey where, from 265 surveys, 126 responses were received. Responses showed the patients rated the practice highly in all areas. For example, data from the national patient survey showed 91% of patients rated the practice as very good or fairly good. The practice scored 96% for the GPs and the 100% for nurses at being good at giving patients enough time and 96% for the GPs and 98% for nurses being good at listening to them. Patients also said the last GP they saw or spoke to was good at treating them with care and concern and the practice scored 97% in this area.

We received 29 CQC patient comment cards and spoke with two patients on the day of our visit. Patients told us they were very satisfied with the service they received. They described the service as exceptional, wonderful, excellent, responsive and efficient. All who commented described the staff as being caring, helpful and respectful. Patients told us all the staff treated them with dignity and respect

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

Care planning and involvement in decisions about care and treatment

The patients we spoke with and who completed CQC patient comment cards were complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and involved them in decisions about their care. The patients scored the GPs highly in the national GP survey in this area. For example, 100% of patients said they had confidence and trust in the last GP they saw or spoke to, 97% said the GP was good at explaining tests and treatments and 92% said they were good at involving them in decisions about their care.

We also received very positive comments about the nurses and patients said they were helpful and caring. The nurses also scored highly in the national GP survey. For example, 96% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments, 95% said the nurse was good at involving them in decisions about their care and 96% said they were good at treating them with care and concern.

Patients said their long term health conditions were monitored and they said they felt very well supported.

We were told care plans had been produced for patients in high risk groups and for those with complex needs, this included those with mental health needs and those patients at high risk of admission to hospital.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted staff responded compassionately when they needed help and provided support when required. One patient described how they felt comfortable to keep returning to discuss any worries they may have until these were resolved.

Notices in the patient waiting rooms and on the patient website informed patients how to access a number of support groups and organisations.

The practice identified carers on the electronic patient record system. Information about various avenues of support was available for carers and they were referred to an appropriate agency for a carers assessment where required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with the local Clinical Commissioning Group (CCG) and nurses attended link meetings for diabetes, tissue viability and immunisation to improve local services.

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 in the way services were delivered. The practice had continually looked to improve patient services and they utilised staff knowledge and skills to provide a number of in-house clinics for patients such as provision of an enhanced service for smoking cessation. .

A record of vulnerable patients such as those with learning disabilities and mental ill health was maintained and regular health checks were provided.

Patients over 75 years had a named GP and the practice had a dedicated telephone number for these patients to speak to a health professional.

Tackling inequity and promoting equality

The practice was situated on the first floor of a purpose built health centre; lifts were available. The patient areas were sufficiently spacious for a wheelchair user. Toilets with equipment suitable for those with a disability were available. Car park spaces were provided outside the front entrance for patients with a disability. A hearing loop was available in the reception area.

The practice web site provided a wide range of information and links to partner organisations. The web site had a translate page function so patients could easily view the website in a language of their choice.

Staff told us where patients attended who did not have English as a first language they had access to translation services and a picture translation book. Information for patients was also available in easy read versions and a sign language interpreter was available for pre-booked consultations.

Access to the service

The surgery was open from 8.30 am to 6 pm week days. On Wednesday and Thursday the closing times were variable as each GP provided some evening appointments, on a rota basis, until 8.10pm. These appointments were pre-bookable only and were primarily for patients who found it difficult to attend during normal surgery hours.

Out of hours services were provided by the practice between 8.00am and 8.30am and between 6.00pm and 6.30pm, Monday to Friday; public holidays were also covered. In all other instances services were provided by NHS 111or 999 services. A NHS walk-in centre was also available locally.

We reviewed the most recent data available for the practice on patient satisfaction with the appointment system. This included information from the national GP patient survey. This indicated the patients were highly satisfied with the appointments system at the practice. For example, results showed 95% of respondents described their experience of making an appointment as good, 85% were satisfied with the surgery's opening hours, 90% found it easy to get through to this surgery by phone and 97% found the receptionists at this surgery helpful. The data also showed 73% of respondents with a preferred GP usually got to see or speak to that GP.

Patients told us appointments were available and they didn't have to wait too long to be seen.

Comprehensive information about appointments was available to patients on the practice website. This included information about which GP was on duty and information about home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

A text message appointment reminder service was available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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 information was available to help patients understand the complaints system on the web site and complaints information was displayed in the waiting area

Good

Are services responsive to people's needs?

(for example, to feedback?)

which included details on how to escalate a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at how the five complaints received by the practice in the last 12 months had been managed. The records showed complaints had been dealt with in a timely way. Patients had received a response which detailed the outcomes of the investigations. We also saw an apology had been given to patients where appropriate. Information on how to escalate their complaint if they were not satisfied with the response was included in the practice information leaflet but was not provided to patient's in the response to a complaint.

We found from records and discussions with staff learning from complaints had been shared with them.

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. The practice had developed mission statement during an away day with staff. The practice aims and objectives included the aim to put patients at the heart of everything they do.

Our discussions with staff and patients indicated the vision and values were embedded within the culture of the practice. Staff and patients told us the practice was patient focused and staff they told us they were well supported.

Governance arrangements

The practice was working together with the neighbouring practice and they were in the process of developing some shared governance functions such as human resources prior to the formal merger of both practices. The management structure was going through a period of change and the practice manager had just been recruited to manage both practices with the former Bridgegate practice manager in post as assistant manager. The managers we spoke with were clear about the plans and changes taking place.

There was a clear leadership structure within the practice with named members of staff in lead roles. For example, one GP was the lead for safeguarding and another GP was the lead for information governance. There were also other staff with lead roles in IT and infection control.

Whilst the GPs and practice manager we spoke with had a clear vision for the practice there was no business plan or development plan available. We also asked to see a financial review of the practice and a financial plan for the future but these were not available. The manager told us the practice accountant had developed a financial plan.

The practice had a number of policies and procedures in place to govern activity and these were available to staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with or above national standards and the practice had achieved almost maximum QOF points at 97.4%.

The practice had evidence of clinical audits which were used to monitor quality and to identify where action should be taken although there was no planned schedule of clinical audit.

The practice had arrangements which identified, recorded and managed risks. Risk assessments had been carried out. Where risks were identified action plans had been produced and implemented although the fire evacuation plan required updating.

Leadership, openness and transparency

The staff told us there was a relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues.

The practice held regular staff meetings. The staff told us there was an open culture within the practice and they said they had the opportunity and were happy to raise issues at team meetings. The staff also told us they had protected learning time and felt supported in their learning.

Patients could access a number of policies and procedures on the practice website and within the practice. For example, procedures relating to complaints, confidentiality and freedom of information were available.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received.

The practice had a small patient participation group (PPG) which was established in March 2010. We spoke with a representative of the group who told us there were approximately five core members in the group and they aimed to meet every two to three months. They said meetings were attended by the practice manager, nurse practitioner and a GP. Minutes were forwarded to the PPG members and displayed on the practice website.

The PPG member told us they completed a practice survey annually. The PPG had been involved in planning the annual surveys, reviewing the feedback and agreeing the action plan. They said the majority of comments on the last survey were positive. They said the practice had responded to any negative comments on the surveys and an action plan had been developed and implemented. For example, comments about lack of reception staff resulted in increased staffing.

Are services well-led?

Good

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

Staff feedback was gathered at regular practice meetings and through annual appraisals. Staff told us they felt comfortable approaching any of the management team.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had been able to develop their skills and knowledge.

The practice had completed reviews of significant events and other incidents and shared the information with staff at meetings to ensure the practice improved outcomes for patients. For example, significant events were reviewed during a weekly multidisciplinary meeting and non-clinical issues were discussed at the weekly staff meetings