

# Brierley Park Medical Centre

## Quality Report

127 Sutton Road  
Sutton in Ashfield  
Nottinghamshire  
NG17 2NF  
Tel: 01623 550254  
Website: [www.bpmcgp.co.uk](http://www.bpmcgp.co.uk)

Date of inspection visit: 13 July 2015  
Date of publication: 12/11/2015

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

### Ratings

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	10
Areas for improvement	10

### Detailed findings from this inspection

Our inspection team	11
Background to Brierley Park Medical Centre	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

## Overall summary

We carried out an announced comprehensive inspection at Brierley Park Medical Centre on 13 July 2015. Overall the practice is rated as good

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. The practice was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff knew how to report significant events and we found that action had been taken in response to safety alerts. Actions were taken following investigations into significant events and these were assessed to consider the impact they had on patients and staff.
- The practice worked with other agencies to help ensure the care and support provided to vulnerable children and adults was coordinated and effective.

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Clinicians introduced the use of Care Bundles to use in association with their QOF data. A Care Bundle is a set of evidenced based interventions that, when used together with QOF data significantly improves patient outcomes.
- Clinical staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All members of the clinical team and non-clinical team worked with families and people with dementia to ensure that they received individualised care dementia friends.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were dealt with appropriately and in a timely manner.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.

# Summary of findings

- The practice openly engaged with the local community where they regularly had a stall at the local community fund day designed to promote a healthy lifestyle.

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

The provider should:

- Ensure that practice policies are more comprehensive.

**Professor Steve Field** CBE FRCP FFPH FRCGP

**Chief Inspector of General Practice**

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff knew how to raise concerns, and to report incidents and near misses. Lessons were learned and changes were made to improve practice. Staff had undertaken training in safeguarding children and vulnerable adults to the appropriate levels and there were arrangements in place to respond to any safeguarding concerns. This was supported through multi-disciplinary working with partner agencies. There were enough staff to keep patients safe. Arrangements were in place to respond to medical emergencies.

Good



### Are services effective?

The practice is rated as good in provision of effective services. We found evidence which showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed clinical guidelines. The practice had achieved 100% of their available points in respect of the Quality and Outcomes Framework (QOF) 2013 to 2014. This was 9.7% above the CCG average and 7.7% above the national average. 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 was using proactive and innovative methods to improve patient outcomes these included the use of a risk stratification toolkit, PRISM which was used to identify those at risk of A&E attendances / admission. The Practice also linked with other local service providers to share best practice.

Good



### Are services caring?

The practice is rated as good for providing caring services. The majority of patients we spoke with were positive about the care they received, and told us they felt respected and listened to by staff. We saw that staff treated patients with kindness and that patient confidentiality was maintained

Good



### Are services responsive to people's needs?

This practice is rated as good for providing responsive services. For example the practice had a high proportion of patients with diabetes. Clinicians introduced the use of care bundles to use in association with their QOF data. A care bundle is a set of evidenced based interventions that, when used together with QOF data

Good



# Summary of findings

significantly improve patient outcomes. In response to the care bundle, the practice had recently instigated “diabetes evenings” a health promotion event designed to educate and empower patients to manage their condition effectively

The practice had initiated positive improvements for its patients which were in response to feedback from the patient participation group (PPG). Patients expressed mixed views about access to appointments. The national GP patient survey published in January 2015 demonstrated that this was an area in which the practice performed lower than the CCG average. The practice had since introduced an urgent care model in order to increase the demand for same day access appointments and this has been well received by patients. The practice was in the process of raising patient awareness about the practice online appointment booking system as there had been limited uptake,

We spoke with representatives of seven care homes who told us the GPs were very responsive to the needs of their registered patients. The practice was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

## **Are services well-led?**

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported and valued by the management. The practice had a number of policies and procedures to govern activity and held a range of clinical and staff meetings. There were systems in place to monitor and improve the quality of services using the data available. The practice acted upon this feedback. The patient participation group (PPG) which also had a “virtual” branch was active, and members we spoke with told us they felt valued. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had a business plan in place which clearly demonstrated ways in which the team intended to move the surgery forward in the coming year. This included ensuring they had extra rooms available for renting to enable them to expand their patient list.

**Good**



# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

### Older people

The practice is rated as good for the care of older people.

The practice had a register of all patients over the age of 75 and these patients had a named GP. There was a nominated GP for each of the seven care homes in the practice area. The practice had identified the most vulnerable 2% of its older population and had care plans in place.

The practice was responsive to the needs of older people. A risk stratification toolkit was used to identify those at risk of A&E attendances / admission. We saw evidence of personalised care plans as part of these unplanned admissions assessments.

We saw evidence that the practice was aware of the impact of loneliness in the elderly population by the amount of referrals to 'Jigsaw'. Jigsaw is a support scheme commissioned by the local CCG to befriend and support individuals identified by clinicians in the practice as lonely.

The care for patients for the end of life was in line with the Gold Standard Framework. The practice worked as part of a multidisciplinary team and out-of-hours services to ensure both consistency of care and a shared understanding of patients' wishes.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

The practice had a high proportion of patients with long term conditions. Nursing staff and named GPs had lead roles in chronic disease management. The practice had achieved 100% of their available points in respect of the Quality Outcomes Framework (QOF) 2013 to 2014, which were above the CCG and national average in all areas. For example, the practice was 1.7 percentage points above the local CCG and 2.8 percentage points above the national average with regard to monitoring patients with asthma. We saw evidence that patients with diabetes and other long term conditions had personalised holistic care plans. The local PPG was working with the practice to arrange special events to support and educate patients and their carers with long term conditions such as fibromyalgia a condition characterized by muscular pain with stiffness and localized tenderness at specific points on the body, dementia and more recently diabetes. Longer appointments and

Good



# Summary of findings

home visits were available when needed. For those patients with the most complex needs, the named GP worked with relevant health and care professionals, for example a diabetes specialist nurse to deliver a multidisciplinary package of care.

## **Families, children and young people**

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 circumstance who were at risk. The practice worked with and was responsive to partner agencies to ensure care for patients assessed as at risk was co-ordinated. A GP took the lead for safeguarding with the local authority and other professionals to safeguard children and families. Staff were proactive in identifying children at risk. All clinicians had received IRIS training.

(Identification of Risks to improve Safety) which is a general practice-based domestic violence and abuse (DVA) training support and referral programme. As a result of this training staff were more vigilant of domestic abuse and made the appropriate referrals where necessary.

In line with the Healthy Child programme, the practice offered six to eight week check for new babies. Staff were aware of the Gillick competencies which are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Appointments were available outside of school hours and the premises were suitable for children and babies.

Childhood immunisation rates were higher than the CCG average. Non-attenders were followed up by practice nurses/GP's and administrative staff.

The practice actively encouraged children to understand the importance of healthy eating by involving local schools in designing art work displaying healthy eating messages. This was clearly displayed in the designated children's area within the practice.

Good



## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students.)

Following feedback from a patient PPG survey, the practice had taken recent action to increase awareness of their online appointment booking system. The practice had extended opening hours to enable patients to make appointments outside of normal working hours.

Good



# Summary of findings

Patients were provided with a range of healthy lifestyle support including smoking cessation with referrals available to external agencies to support people in leading healthier lifestyles.

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

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients who had a learning disability and offered annual health checks to this group of patients. We saw evidence that 37 out of all 67 patients on the register had all their health checks completed. Staff were working to ensure that all clients from this group had their health checks completed. Patients with a learning disability had a named GP and also a named nurse who was trained in learning disability management.

If a patient with a learning disability declined a health check, the patient would be invited to attend an appointment with the specialist nurse who worked with the individual patient to identify the reason why they would not attend for their health check to enhance patient care.

The practice had systems in place to identify those individuals who had no fixed abode and we were informed that any patient on the current register who became homeless for any reason would be kept on the register unless there were extenuating circumstances. For example safety of staff or other service users.

The practice used interpreter services for those patients whose first language was not English. It offered double appointments for a number of patients whose circumstances may make them vulnerable. Staff at the practice were aware of the arrangements in place to safeguard their patients, and how to respond to concerns.

Information about how to access support services was available in the practice. Owing to the high proportion of patients in the seven care homes for which clinical staff had responsibility, all clinical staff had been trained to recognise when deprivation of liberty safeguarding assessments (DoLS) were required. DoLS have been designed to make sure that residents in care homes hospitals and supported accommodation are living in a way that does not inappropriately restrict their freedom

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Patients experiencing poor mental health were invited for annual health reviews. The practice worked with multi-disciplinary teams to

Good





# Summary of findings

support people experiencing poor mental health including those with dementia. All staff had received Mental Capacity Act (2005) training and four of the GPs worked closely with people with dementia and their families to ensure they received individualised personal care.

The practice made referrals to a specialist mental health therapist who held regular weekly clinics at the practice to enhance the quality of patient care provided for these patients. Patients were also referred to MIND which is a support group for people experiencing mental health problems. Patients were also referred to a local counselling service where appropriate.

# Summary of findings

## What people who use the service say

Data from the national GP patient survey, published in July 2015, identified that 89% of patients reported that their GP was good at listening to them (compared with the local CCG average of 86% and a national average of 89%), and 85% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care (compared with the local CCG average of 79% and a national average of 81%).

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We reviewed the comments on the nineteen cards completed by patients. The majority of patients were positive about their experience of the care they received at the practice. Comments were mainly positive about the staff, referring to both their kindness and helpfulness. Those who commented reported they felt they were listened to and involved in decisions about their care. We spoke with eight patients on the day of our inspection. We also spoke with a further six patients who were members of the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Patients told us they were treated with dignity, respect and felt listened to. They told us that they were happy overall with the service provided at the practice. Patients said they could get a same day emergency appointment. However, we received mixed comments with regard to waiting times for seeing the patients' GP of choice and the ease of obtaining a non-urgent appointment.

We spoke with representatives of seven care homes for older people in the area. People living in these care homes received their primary medical service from the practice. We received positive comments about the support provided by the GPs, and how they related to people living in the care home.

The representatives of the PPG with whom we spoke, told us they felt the practice both listened to and acted on their views. They said they were involved in discussions about the actions the practice planned to take following suggestions made by patients. Patients were actively encouraged to use the suggestion box in reception, on line or in person to discuss with staff ways in which the practice could be improved.

The practice has patient representatives who take an active role in the Huthwaite Involving Patients Group (HIP) which works with the PPG to help the practice understand the needs and expectations of the wider patient population. This group also told us that they felt the practice both listened to and acted upon their views.

The practice had recently carried out the NHS Friends and Family test (FFT). This showed that 90% of all patients who completed the FFT would recommend the practice to others.

## Areas for improvement

- Ensure that practice policies are more comprehensive

### Action the service SHOULD take to improve

- Ensure that practice policies are more comprehensive

# Brierley Park Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service

## Background to Brierley Park Medical Centre

Brierley Park Medical Centre is a well-established practice caring for 8,655 patients in Huthwaite and Sutton in Ashfield, together with the surrounding Derbyshire villages. The practice is located within the Ashfield District Council area and levels of deprivation for the practice population are above the national average. The practice has extended opening hours and is open from 7am to 6.30pm, Monday to Friday. The practice closes on one Wednesday afternoon a month to allow for staff protected learning time.

Brierley Park Medical Centre holds a General Medical Services Contract to provide primary medical services. This is a contract between NHS England and general practices for delivering general primary care medical services including minor surgical procedures. The practice has opted out of providing out of hours services, which is provided by Central Nottinghamshire Clinical Services (CNCS) and Primary Care 24 (PC24).

There are five GP partners working at the practice, working various hours, which in total provide a service for patients which equates to 3.88 whole time equivalent GPs. The

practice has three female and two male GPs. The practice is a training practice and provides work placements for doctors in training (GP registrars) and Foundation Year Two (FY2) doctors. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. FY2 doctors are qualified medical graduates who are undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. Currently, there are two GP registrars and one FY2 doctor at the practice. The practice team included two practice nurses, one nurse practitioner (non-medical prescriber) and two healthcare assistants. The practice management includes a practice manager and a deputy practice manager.

## Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

## 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?

# Detailed findings

- 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew including commissioners, the area team from NHS England and Health Watch. We carried out an announced inspection on 13 July. During our inspection we spoke with a range of staff, including doctors, nurses and administrative staff. We spoke with eight patients who used the service, and six members of the practice patient participation group. We reviewed the policies, protocols and other documents used at the practice. We reviewed 19 completed comment cards and spoke with representatives of seven care homes with patients registered at the practice.

# Are services safe?

## Our findings

### Safe track record

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events and complaints and the actions resulting from them were documented in individual event records as well as a summary. The summary indicated trends such as patient misidentification or external organisation involvement. There were 14 events captured on the summary. We saw evidence from meeting minutes that these events had been followed up appropriately and in a timely manner.

The practice used a range of information to identify risks and improve patient safety. Clinical meetings were used to discuss safety alerts. For example National Patient Safety Alerts (NPSA) and Medicines and Healthcare Regulatory Authority (MHRA) alerts. Staff could describe a recent alert and explained that alerts were discussed at clinical meetings. There was a safety alerts protocol in place for staff to refer for support and guidance. During our inspection we saw that action had been taken by the practice in line with this protocol.

Staff we spoke with confirmed that safety alerts were received by email and that different clinicians in the practice took responsibility for different alerts. For example one clinician was responsible for managing risk alerts with regard to medical equipment.

We saw documentation from the local CCG pharmacist which demonstrated that the practice worked with a member from the medicines management team in the audit of medicines following alerts received. The CCG is the local Clinical Commissioning Group responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. The CCG Pharmacist also praised clinicians for acting very promptly when alerts with regards to medicines had been received. We saw evidence of the changes made to patients' prescriptions in terms of these medicines.

### Learning and improvement from safety incidents

The practice had a system in place for the reporting and recording of significant events. Staff used forms which were available on the staff intranet. We saw a summary of the 14 reported significant events over a 12 month period.

There was evidence that significant events were logged and investigated thoroughly. We found evidence of learning from all significant events. Action plans were put in place with a review date to monitor that any changes made had been effective. Staff we spoke with knew how to report significant events, and we saw records which demonstrated that significant events were discussed at significant event meetings where all practice staff attended on a quarterly basis but were more frequent if anything serious was identified. Staff we spoke with were able to tell us about a recent significant event.

The practice had also initiated a Safety Climate Survey (SCS) to gain an insight into the organisation's safety culture and evidenced based suggestions for improving it. Data showed that the practice had achieved broadly similar scores in respect of how they managed significant events. The practice planned to repeat this survey to ensure that they were practicing safely and effectively.

The practice had also employed an external agency to carry out a Health and Safety Survey

Report which we saw was carried out in June 2015. This survey did not highlight any cause for concerns.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We saw evidence that safeguarding policies were available to staff. Contact details of key staff in partner agencies were available in the consultation/treatment rooms.

The practice had one lead GP for safeguarding vulnerable adults and children. All clinical staff we spoke with were aware of actions to take if they had safeguarding concerns, and knew who the lead person was for safeguarding in the practice. The safeguarding lead GP was trained to the appropriate level. Nursing staff had received training in child protection to the level appropriate to their role. All staff had received the appropriate level of vulnerable adult safeguarding training.

Where there were concerns related to children's safeguarding these were noted on the patients' records.

## Are services safe?

Multidisciplinary safeguarding children meetings took place every quarter with all members of the multidisciplinary team including health visitors, a midwife and school nurses. We saw evidence from the minutes of these safeguarding meetings. The lead GP for safeguarding told us that these meetings were helpful in identifying shared concerns. The lead GP had completed an audit on who attended the practice with their child and whether or not a child attended on their own. This is considered to be best practice to assist clinicians in identifying safeguarding risks for children.

The practice monitored children's attendance at the accident and emergency department and these patients were reviewed accordingly.

The practice had a chaperone policy which included details about who could chaperone and the action to take if a chaperone were not available. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. During our inspection, only GPs and nursing staff were trained as chaperones. However, the lead GP told us they had identified several administrative staff who were to be trained as chaperones in order to cope with patient demands. We saw that these administrative staff had Disclosure and Barring Service (DBS) checks in place to allow them to fulfil their duties as chaperones safely. Information about the availability of chaperones was available in the practice waiting room.

### Medicines management

Patients ordered repeat prescriptions in person or on line. There was a team of receptionists and administration staff who had been trained in managing repeat prescriptions. We saw evidence that the receptionist checked the name of the patient, their date of birth and how many times the medicines had been dispensed before requesting a GP to authorise the repeat prescription. This was in line with the repeat prescribing policy which we saw on the day.

Managers reported that the arrangements for managing prescriptions and undertaking medicines reviews for patients living in the seven care homes that the practice visited worked well. The practice had now started to use the electronic prescribing service.

There were systems in place to manage the stock control of vaccinations. The expiry dates of medicines were routinely checked and documented. We saw evidence that all the

vaccines fridges were stored securely and were only accessible to authorised staff. The fridge was not locked upstairs in the practice, but we saw evidence that this had clearly been risk assessed and was deemed safe as it could not be accessed by members of the public. All of the vaccines we checked were in date, stock was rotated and the expiry dates were clearly recorded

Records were kept of the temperature of the two vaccine fridges. Temperatures were within the required temperature range. The fridges had a thermometer probe cable, an external thermometer and a USB data probe which monitored the fridge temperature. There was no thermometer to measure the temperature of the clinical rooms where medicines were stored. It is best practice to have a thermometer in the clinical rooms as the efficacy of some medicines is affected when the temperature reaches over 25 degrees centigrade.

The nurse we spoke with was able to discuss the action they would take if a vaccine fridge had broken down which was in line with practice policy. We saw evidence that measures were in place to ensure that vaccines were kept at the right temperature to ensure they were effective, including in the safe transportation of vaccines to the care homes. .

The medicines in the treatment rooms were stored securely, were in date and the expiry dates were recorded.

The practice had received notification from the Medicines Management Team from the local CCG in 2014 which suggested that they were overspending on their prescribing. We saw evidence from the local CCG prescribing incentive scheme 2015 which highlighted that the practice was now prescribing antibiotics more efficiently, following the adoption of a delayed prescribing policy.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

### Cleanliness and infection control

We observed the premises to be visibly very clean and tidy. Patients we spoke with told us they found the practice very clean and had no concerns about infection control. We saw evidence of a cleaning schedule completed by a company

## Are services safe?

which was independent of the practice. We saw evidence that the practice manager often carried out “spot checks” to ensure that the cleaning of the practice was of a safe and high standard.

The practice had an infection prevention and control policy. We saw an infection control audit had been undertaken in July 2014 by an independent company. Any action points highlighted had been actioned. The surgery had a lead in infection prevention and control. Other staff received role specific training in infection prevention and control.

Hand gel was available throughout the practice in both the private and public areas. We saw that spillage kits body fluids were available. We saw evidence of one of these spillage kits being used effectively during our inspection. The curtains in the consultation and treatment rooms were changed every six months. Where curtains were made of material we saw evidence that these were changed on a regular basis. A waste management contract was in place.

A legionella risk assessment had been carried out by an independent provider in 2014. (Legionella is a particular bacterium which can contaminate water systems in buildings). There were regular tests undertaken to ensure the water system was free from harmful bacteria.

Both clinical and non-clinical staff had received training in recognising the signs and symptoms of the Ebola Virus. We saw evidence of an “Ebola Kit” which was stored in the treatment room and all staff we spoke to knew where to find this. Records were kept of hepatitis B vaccinations of all clinical staff. This included when the vaccination was next due. This vaccine offers protection to staff if they have come into contact with infected blood or needles

### Equipment

We saw that portable appliance testing (PAT) took place in July 2015 at the practice and all equipment had been tested as required. We saw that equipment had been calibrated. Sufficient equipment was available for staff to enable them to carry out diagnostic examinations.

### Staffing and recruitment

The practice had a comprehensive recruitment policy. Criminal records checks had been carried out through the Disclosure and Barring Service (DBS). We saw records that

all clinical staff and any non-clinical member of staff who had contact with patients, including those who were to become involved in chaperoning had been subject to a criminal records check.

When needed, the practice used locum GPs. We saw evidence that the practice received copies of the checks carried out on any locum GP, for example their criminal records check, their clinical working experience CV, medical registration information and insurance details. There was a locum pack available providing information about the local area and details of clinical arrangements the practice had with regards to patient referrals.

### Monitoring safety and responding to risk

The practice had a health and safety statement policy which set out the responsibilities of the provider and staff in ensuring the health, safety and welfare of patients, staff and any others on the premises. A health and safety risk assessment had been undertaken and a Health and Safety Law poster was displayed. A Safety Climate Assessment had also been initiated by the practice. A Safety Climate Survey Tool helps providers to gain a unique insight into the organisation’s safety culture and evidenced based suggestions for improving it. This survey highlighted that when staff were under increased pressure team members worked well together and at a fast pace to ensure patient safety. The same survey also found that the level of staff in the practice was sufficient to manage workload safely.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator. This is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff knew where to access this equipment and the evidence we saw showed that this emergency equipment was checked on a weekly basis to ensure it was working.

Emergency medicines were kept in emergency boxes in both the GPs and nurses rooms. We saw three specialist medicines within the vaccination fridges which could be used in the event where a patient suffered a reaction to any



## Are services safe?

medicine. We saw evidence during the inspection of a spread sheet of each GP's emergency medicine and nurse's medicines with expiry dates clearly recorded. These medicines were all in date.

Staff could describe the actions they would take in the event of a medical emergency at the practice. During our inspection we witnessed a receptionist taking prompt action to refer a patient to the emergency services after they had telephoned the practice in distress and pain. We observed that the receptionist made sure that the patient could access 999 before the call was discontinued.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included lack of access to the premises, loss of electricity or gas supplies, failure of the IT system and loss of medical records amongst others.

A fire risk assessment had been undertaken. Fire safety equipment was available and maintained. All staff we asked described the procedure for safe evacuation during a fire. We also saw evidence that staff had attended fire drills.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinical staff were familiar with current best practice guidance for example with guidance from the National Institute of Care and Health Excellence (NICE). Guidelines were discussed at clinical meetings which were attended by all clinicians at the practice and were disseminated to staff both electronically and as a hard copy.

Areas of specialism were led by different clinicians in the practice, for example there was both a lead GP and lead nurse who took responsibility for managing individual long term conditions.

New patient healthcare checks were offered and we saw evidence that 84% of patients aged between 40-74 had received NHS health checks. We saw evidence that there were health checks for all patients registered with learning disabilities at the practice and for those with mental health needs. For example, 91% of patients diagnosed with dementia in the practice had received an annual review and health check.

The proportion of patients attending accident and emergency (A&E) departments at the practice was 5.4% lower than the Clinical Commissioning Group (CCG) average. The practice used a risk assessment tool to identify those at risk of A&E attendances / admission.

Referral letters to secondary care were usually passed to the administrative staff the same day the patient was seen.

The practice referred to Quality and Outcomes Framework (QOF) data to monitor their performance and we saw evidence that the practice had a higher than average number of patients with long term conditions. The practice had achieved 100% of their available points in respect of the Quality and Outcomes Framework. This was 9.7% above the CCG average and 7.7% above the national average. However, the QOF data did highlight that there was an issue with under reporting for those individuals who suffered with Chronic Kidney Disease (CKD). When we asked the lead GP why this was the case, she told us that she was aware of this and intended to carry out a search using their electronic system to identify all the patients on the list who were at risk of developing CKD. Once these

individuals had been identified they would then be offered appropriate blood tests and investigations to clarify the diagnosis of CKD which would lead to more accuracy in reporting of data.

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. For example, a GP told us that if a patient who had a learning disability (LD) did not attend for a health check, the nurse who was trained in LD support and management at the practice would work with the patient to clarify why they had not attended.

### Management, monitoring and improving outcomes for people

The practice undertook audits to monitor and improve outcomes for patients. We saw evidence of six audits carried out between 2011 and 2015. The audit cycles were complete cycles which included a second audit in order to demonstrate improvement in patient outcomes.

The practice conducted an annual audit of all minor operations to look at what minor surgical procedures had been undertaken and to identify any complications including wound infections and open wounds. The results from both the 2013/14 and 2014/15 audits showed that the complication rates were fairly static. However, the 2015 audit did identify that there was an increase in poor wound healing in some areas which was attributed to more complex surgical procedures. These findings were to be discussed at the next clinical meeting in order to make suggestions as to how wound healing may be improved.

### Effective staffing

Practice staffing included medical, nursing, and administrative staff. There was a practice manager and a deputy practice manager employed.

All GPs had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice employed two practice nurses and one nurse practitioner and there was evidence to show the practice manager had undertaken regular checks on the status of

# Are services effective?

(for example, treatment is effective)

the nurses' registration with their professional body; the Nursing and Midwifery Council. The nurses we spoke with were aware that they were required to undertake revalidation with the Nursing and Midwifery Council which is a mandatory process for all nurses enabling them to renew their registration.

Staff appraisals took place for all clinical and non-clinical staff. Staff training was based on need, and was intended to support improved outcomes for patients. We saw evidence that the training was recorded.. Nurses worked within their scope of practice. For example the health care assistant was supervised by a GP in the administration of flu vaccines, and was mentored by the lead practice nurse. There was evidence that staff were given feedback on their performance and areas for development.

The locum GP and Foundation Year Two (FY2) doctor confirmed that they had had an induction when they started work at the practice. FY2 doctors are qualified medical graduates who are undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. This induction pack included the organisational structure, a staff list including roles, the code of conduct including confidentiality and safeguarding arrangements.

Staff had access to online training; in house training courses and training provided by external agencies. The training records we saw showed that all staff had received adequate training in safeguarding. Where there were concerns about performance of staff this was addressed.

Staff informed us that due to annual leave and long term sickness there was a shortage of staff. However we saw evidence that clinics had been rearranged and the practice had organised for all members of the administration team to take on other administration areas to ensure that patient care was not compromised. We were satisfied that this was safe.

## Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All patient hospital discharge letters and any patient who had attended an out

of hours setting or a walk in clinic were reviewed by the GPs they were scanned in to the practice system on the day of receipt. If a GP was absent any incoming letters and results would be reviewed by a colleague GP.

We also saw evidence that there was a comprehensive system in place to ensure that patients were informed about abnormal blood results. When blood results were received by the practice they were documented onto a spreadsheet and it was recorded when the result had been seen by the doctor and actioned. The same spreadsheet also directed receptionists as to the action required for when a patient called in to request their results. This system was in place to ensure that abnormal blood results were not missed or patient care compromised.

The practice held monthly multidisciplinary team meetings to discuss adult patients with complex needs, those who were frail and patients who had attended accident and emergency or who had had contact with the out of hours service. These meetings were attended by the community matrons, care co-ordinator, GPs practice nurses and one of the practice managers. Regular multi-disciplinary meetings were held to share information about children at risk. Staff reported that these arrangements for multi-disciplinary working were effective and worked well.

We were told by a representative of a care home that the practice worked with patients with a learning disability, empowering them to manage their healthcare needs where appropriate.

## Information sharing

The practice used an electronic system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Where patients had attended out of hours we saw that this information was scanned into patients' notes and dealt with by the relevant named GP where available, on the same day.

Electronic systems were in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients could make

# Are services effective?

## (for example, treatment is effective)

the hospital appointment whilst they were still at the surgery after seeing the GP. However, if this was not possible patients were told they could call the surgery to make the arrangements on their behalf.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The nurses we spoke with had both received training in the Mental Capacity Act 2005. The nurse we spoke to was able to provide a very good example of where she had to obtain consent from a patient with a learning disability before they underwent ear syringing, a technique used to remove excess wax from the external ear canal.

Care home staff we spoke with confirmed that the GPs involved patients living in the care home about decisions about their care, and were aware of when patients may lack capacity, for example patients with dementia. In these situations the GPs liaised with the care home staff who knew the patients and their families well

We saw that all staff had received in house training to familiarise them with Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.) We found the clinical staff we spoke with understood the key parts of the legislation and were able to describe, using the different scenarios, how they implemented it in their practice.

The nursing staff we spoke with were aware of the arrangements for gaining parental consent before issuing a vaccine. They were clear that childhood vaccinations would not be given if the child was brought in by a person other than the parent, for example by a grandparent or child minder, unless appropriate safe consent had been provided. The nursing staff were aware of the importance of obtaining informed consent from patients. Both the nurse and the GP registrar we spoke with said they described in advance the examination or treatment to the patient before proceeding to gain informed consent. A GP also informed us about how they made sure information was available to patients prior to giving consent to any minor surgery. We saw an example of a consent form that had been completed for a patient who had undergone a minor surgical procedure.

Information about advocacy services was readily available in the patients' waiting room. Staff were aware of advocacy services and some told us they accessed this information using the practice's computer system. For example, patients who have problems with alcohol could be referred to the Nottinghamshire Recovery Partnership Scheme for support.

### Health promotion and prevention

The practice kept a register of patients with a learning disability (LD) and invited these patients to attend for an annual health check. At the time of our inspection 37 out of 67 of these patients had received their annual health checks. Staff were working to improve in ensuring all clients from this group had their health checks. For example the nurse who was specialist in LD care was working with LD clients who had needle phobias in order to help them to attend for their health checks.

The practice had referred 83% of their patients from all age ranges who smoked, for smoking cessation advice run by the New Leaf service. We saw evidence from practice records that 18% of those individuals referred were recorded as having stopped smoking.

The practice's performance in respect of the percentage of women who had attended for cervical screening was 80% which was higher than the CCG average of 79% The practice performance for bowel cancer screening was 61% which was above the CCG average of 57%, However breast screening uptake was recorded as 78% which was marginally lower than the CCG average of 81%. We saw evidence that the practice was actively encouraging patients to seek screening by providing information on this and other health promotion measures in their specialist health promotion hub.

The practice had performed in line with other local practices in respect of the number of patients who had received a flu vaccine. For example, the practice achieved a 77.3% uptake for the flu vaccine in those aged 65 years and over which was above the CCG average of 74.4%. The uptake for flu vaccination in those aged 65 years and under was recorded as 54.5% which was higher than the CCG average of 49.6%.

Childhood immunisation rates were at 100% for those over five years of age and 96% for those children under five which was above the CCG average.

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

The practice offered a six to eight week check for new babies which included a post natal check for the mother and vaccination/development check for the baby. A medical questionnaire was available for new patients to complete as part of the registration process. This was available online. New patient checks were available with the healthcare assistant for new patients.

The ethos of the practice included promotion of health and wellbeing. The practice leaflet provided comprehensive advice on the treatment of minor illness and signposted patients as to the services available in the practice. The practice leaflet could be accessed online.

Health promotion information was available in the patients' waiting room. This was in a dedicated area known as 'the hub.' This included, facilities to monitor weight, eating well with diabetes, traveller health including travel to the Middle East, dental care and sexual health. There was information about common viruses and how to treat them. Patients could also use the computers provided to search for health related literature. The practice website provided a search facility for services such as opticians and dentists.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We saw that patients attending the reception area of the practice were treated with respect. There had been previous concerns raised by the Patient Participation Group (PPG) with regards to maintaining patient confidentiality. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. However, the practice had recognised this and there was a rope barrier to indicate where patients should queue to help respect confidentiality. We saw there was a room set aside where patients could discuss matters of a confidential nature. The switchboard was situated in a room behind reception and during our inspection we saw no breaches of confidentiality. The practice had also ensured that all their clinical consulting rooms were soundproofed to ensure that confidentiality was maintained at all times.

Patients we spoke with were mainly positive about how they were treated by staff. We saw evidence of communication from a patient thanking the receptionist responsible for repeat prescriptions, assisting them to gain access to a medicine that was urgently required whilst they were away.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received 19 completed comment cards. The majority of comments we received were positive about their treatment by staff. They described staff as friendly, respectful and helpful. Six patients commented on how staff at the practice took time to listen.

In the national GP patient survey published in July 2015, 89% of the patients reported that the last GP they saw or spoke to was good at listening to them, which was above the local CCG average of 83%, and the national average of 86%.

We reviewed those comments to Health Watch and NHS Choices over the preceding 12 months. Some comments were positive about their experience at the practice and others less so; referring negatively to the availability of appointments. The practice had responded to these comments on the website.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. The practice also had the same information available on their practice leaflet and online.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decisions about their care. They told us that the staff took time to explain things to them.

Those patients, who commented, using our comment cards, did not raise any concerns about their involvement in their care.

Data from the NHS GP patient survey from July 2015 identified that 89% of respondents said that the last GP they spoke to was good at explaining tests and treatments, which was above the local CCG average of 86%. Eighty five percent of respondents indicated that the last GP they saw or spoke to was good at involving them about their care, this was above the CCG average of 81%.

Representatives of the care homes we spoke with said they found the GPs at the practice were courteous and involved patients in discussions about their care.

During our discussions with staff we were provided with examples of where staff had assisted more vulnerable patients to make decisions about their care arrangements.

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

Notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations. Information was available about support groups and organisations. For example, to support patients with asthma, patients experiencing poor mental health and those who had had a stroke. There was also information provided for the elderly to access a local support group 'Jigsaw' which was designed specifically to help alleviate loneliness in this group.

The practice had a carers' identification protocol which included how to identify a carer, recording information on the patients' records and maintaining a register of carers. Information for carers was available in the waiting room, displayed on the TV monitor and in the health promotion hub.

## Are services caring?

We saw evidence of a letter from a relative thanking staff for the support one of his parents had received allowing them to stay in their own home with a much better quality of life.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice had considered the potential for increased demand for patients to register with Brierley Park Medical Practice. For example, the practice had discussed the potential need to increase staffing levels with the CCG and the landlord of the building to ensure that extra rooms were available for rent should the need arise.

The practice understood the needs of its diverse patient population which included members from different nationalities. We saw evidence that interpreters were booked for patients where English was not their first language and that appointment times were extended to 20 minutes to accommodate their needs.

The practice had seventeen patients on their palliative care register. We saw evidence these patients were identified on the system by a gold star. We saw evidence that the care and attention these patients received was in line with the Gold Standard Framework. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programs, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life.

A care home representative told us that they found the practice was very responsive to patients' needs with the GPs responding promptly if a patient living in the home became acutely unwell. We were informed that the GPs supported patients to remain at the care home and reduce any need for a hospital admission.

The practice had a high proportion of patients in their care who suffered with diabetes. Whilst they were achieving 99.8% on their QOF data in this area clinicians were not satisfied that patients were receiving the best evidenced based care. Therefore the clinicians introduced the use of care bundles to use in association with their QOF data. A care bundle is a set of evidenced based interventions that, when used together with QOF data can improve patient outcomes.

In response to the care bundle, the practice had recently instigated "diabetes evenings", a health promotion event designed to educate and empower patients to manage their condition effectively. We saw evidence from the patient participation group (PPG) minutes from April 2015

which gave very positive feedback on the diabetes evening. However, as this work was in its infancy there was not any other clinical data to suggest its long term effectiveness to date.

The practice had a comments box in the patient waiting room area. Representatives of the patient participation group (PPG) told us that any suggestions made were discussed at the PPG meetings. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

PPG representatives told us of changes made by the practice following discussions with them. For example, patients had identified a need to improve the delivery of repeat and electronic prescriptions to the practice pharmacy. We saw evidence from the PPG minutes dated May 2015 which suggested that the situation had improved and that the onsite pharmacy had extended hours to accommodate patients' needs.

The PPG was also aware that their membership did not reflect the local population. The minutes from the Patient Participation Enhanced Service Report (2014/15) recognised that the PPG was underrepresented for mothers with young children. More recently, the practice had an influx of patients from Eastern Europe which were not represented. The PPG were working with the practice to actively try and recruit such individuals. This was to be achieved by publicising the need for PPG members on the practice website, by attaching PPG information to all new patients registering with the practice and writing to care homes, in particular those which catered for younger adults with learning disabilities in an attempt to recruit the patients and or their carers.

### Tackling inequity and promoting equality

We saw evidence displayed in the practice, both in the practice leaflet and on the TV monitor that translation services were available to support patients where English was not their first language in their consultation.

We also saw evidence on the electronic booking system that patients were able to make appointments with male or female GPs.

# Are services responsive to people's needs?

(for example, to feedback?)

The practice had 67 patients with a learning disability who were registered with the practice and we saw evidence on the electronic booking system that these individuals were offered extended appointment times to accommodate their needs.

The premises had lift access enabling access to patients who had a physical disability or mobility difficulties. We saw a dedicated room was available for mothers who were breast feeding. During the inspection we observed that adequate baby changing facilities were available.

The practice had a loop system for patients who had a hearing impairment.

The practice registered patients who were of no fixed abode.

## Access to the service

The national GP patient survey published in July 2015 noted that 71% of respondents described their experience of making an appointment by phone as good. This was broadly in line with the Clinical Commissioning Group average of 72%. Ninety- six percent of patients described their last appointment as was convenient which was above the CCG average of 94%. The practice had advertised that patients could make appointments on line. However, to date there was a poor uptake with this service and the practice was taking steps to rectify this by publicising the online appointment system within the practice.

Appointments with the GP, HCA and nurses were available on Monday to Friday from 7am to 6.30pm. The practice closed on one Wednesday afternoon a month for staff protected learning time. The practice had extended hours from Monday to Friday from 7am to 8am. Data from the Patient Participation Enhanced Service Report 2014/2015 gave positive feedback from patients with regards to extended opening hours. Three patients we spoke to on the day also confirmed this finding.

The practice had invested in a new Urgent Care Clinic in response to patients who had complained about same day access to appointments. We saw evidence from the practice's own Urgent Care Clinic Patient Satisfaction Survey from January 2015, where 81 out of 127 patients said that it was very easy to book an urgent appointment. We saw evidence that the practice was in the process of applying to the CCG for funding for an additional GP to help

with the Urgent Care appointments. The practice believed that another doctor could help alleviate some of the pressure on pre-bookable appointments thus improving patient access.

The practice had a Nurse Practitioner, also a non-medical prescriber who undertook the minor illness clinics.

Three patients who completed our comment cards commented positively on the arrangements to get an emergency appointment. Six patients we spoke with on the day also confirmed that they felt it was easy to obtain an emergency appointment. In addition one patient who completed our comment cards reported that they were usually able to see the same GP.

The practice GPs also offered telephone appointments where necessary.

The practice website, practice leaflet and television monitor within the practice provided contact details of the 111 service which was available outside of the practice opening times. The practice leaflet, website and television monitor also provided contact details for nearest Walk In Clinic and a telephone number for the local out of hours service when the practice was closed.

The practice had introduced a localised service for the screening of abdominal aortic aneurysm (AAA) which is routinely offered in local hospitals but not in rural GP practices. An abdominal aortic aneurysm (AAA) is a swelling (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body. The swelling has the potential to burst which is why it is important to screen patients to see if this defect is present. The practice also had a specialist dermatology clinic based within the surgery which was designed to save travelling costs for their patients.

## Listening and learning from concerns and complaints

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

Information about how to complain was displayed in the practice for patients. We saw evidence on the television monitor in the practice and in the waiting area to this effect. The practice leaflet and website provided information for patients on how to complain.



## Are services responsive to people's needs? (for example, to feedback?)

We found that all patient complaints were investigated and appropriately responded to in a timely manner. All the complaints we reviewed offered the patient an apology. We found that complaints were discussed during the weekly clinical meetings. This was reflected in the minutes of the March 2015 clinical meeting which we reviewed. We were

informed by the practice manager that the learning from any complaints was discussed with any staff directly involved. We saw evidence that this was the case from the annual review of complaints meeting held in March 2015. Members of the PPG also attended this annual complaints review meeting.

# 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 mission statement which had been developed with staff. We saw a business plan which addressed the financial aspects and other potential business changes designed to move the practice forward in the next year.

All staff spoken with described the practice ethos as one in which they aimed to treat patients with respect, provide equal treatment for all patients and that the practice was patient focussed.

### Governance arrangements

We reviewed five policies and procedures and found that whilst they were all up to date they were lacking in detail. For example, the health and safety policy lacked detail which could impact on patient care, although the practice had many risk assessments for health and safety in place. The practice manager acknowledged that the health and safety policy was too short and we were assured that she would be taking action to amend this. The policies and procedures were available on the practice's computer system.

Different staff had lead roles within the practice, and every GP partner had a lead role. Examples included safeguarding, IT, the Quality and Outcomes Framework (QOF) and managing the practice nurses. Individual GPs took responsibility for different long term conditions. This was reflected in the practice minutes where we saw evidence of actions to be taken from safety alerts, significant events and patient complaints.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (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). We found that the QoF data was used to help drive improvements in the services provided. Staff told us that QOF data was regularly discussed at the general practice meeting. The minutes we saw reflected that all areas of performance were discussed and included forward planning and any outstanding areas of work to be addressed.

### Leadership, openness and transparency

The practice held regular monthly practice meetings. Staff described the meetings as a forum for a two way conversation. Staff told us they felt valued and listened to. The practice manager told us that the management team had an open door policy. The nursing staff we spoke with said the senior staff were approachable. Although there was a designated lead GP for the nursing team, we were told by one of the nurses with whom we spoke that they could approach any of the GP partners.

A staff whistleblowing policy was in place in the practice.

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

The practice had a PPG that met together. They also had a virtual PPG, where patients did not meet in person but communicated online. The PPG representatives we spoke with told us that they received feedback on patient and public suggestions submitted using the suggestion box in the waiting areas of the practice. They told us that they felt that feedback they gave was taken account of by the practice. We saw evidence that this was the case on the website where there was a section entitled 'we do listen'. We saw that the practice considered areas for improvement arising out of complaints; for example improving the appointments system and improving the way in which the practice pharmacy worked with the practice in handling repeat and electronic prescriptions.

### Management lead through learning and improvement

We found that staff had regular appraisals, which included a development plan. There was evidence that staff were supported to attend training to improve the services provided to patients. Staff we spoke with confirmed that the practice was pro-active in respect of training. This included both online learning as well as other courses dependent on need.

The practice was a training practice. The trainee GP we spoke with was positive about their experience at the practice and we also saw a thank you card from a previous GP registrar who was very sad to leave the practice. The practice is now working towards receiving medical students (doctors in training) in the near future once they have the staff available to accommodate their training needs.