The Tutbury Practice

Quality Report

Monk Street
Tutbury
Burton on Trent
Staffordshire
DE13 9NA
Tel: 01283 812210
Website: www.tutburypractice.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 15 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice could demonstrate improved outcomes for patients through the use of a comprehensive range of clinical audits.
- The practice had introduced 'dual clinics' so patients with more than one long term condition were assessed for all of them at a single appointment rather than being recalled separately for each condition.
- The partners provided strong and clear leadership which had led to a committed and motivated staff group.
- The practice was responsive to its different patient groups and patients were overwhelmingly satisfied with the service they received.

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

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. National Institute for Health and Clinical Excellence (NICE) guidance was referenced and used routinely. Clinical audits were routinely used to help improve outcomes for patients. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. The practice could identify all appraisals and the personal development plans for all staff. There was evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. There was a clear leadership structure and staff felt supported by management. Governance and performance management arrangements had been proactively reviewed. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG).

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. They described the staff as knowledgeable, kind, caring and supportive. Patients also told us that they were involved in decisions about their care and treatment, and that they were treated with dignity and respect. We collected 16 Care Quality Commission comment cards from a box left in the surgery in the week before our visit. The comments on the cards were overwhelmingly positive. Two patients commented that it could sometimes be difficult to get an appointment. One patient said they felt uncomfortable having to explain their reason for wanting to see a GP to a receptionist. Nearly 150 patients responded to the practice's own most recent survey. The results were very positive. Over 97% of the practice's patients who responded said they were satisfied with the service they received from the practice.

Outstanding practice

The practice had introduced 'dual clinics' so patients with more than one long term condition were assessed for all of them at a single appointment rather than being recalled separately for each condition.

The Tutbury Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse and a CQC deputy chief inspector.

Background to The Tutbury Practice

The Tutbury Practice provides a range of primary medical services to just under 7,000 patients from purpose built premises situated at Monk Street in Tutbury near Burton on Trent in Staffordshire.

There are currently three GP partners at the practice and one salaried GP. There is also a Registrar (trainee GP). There are three practice nurses, a health care assistant and a phlebotomist (someone who takes blood samples) based at the surgery. There are a total of 35 GP sessions each week and 15 sessions held by the practice nurses.

The practice has opted out of providing out-of-hours services to their own patients. Out of hours care is provided by a separate organisation.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced inspection on 15 October 2014. During our inspection we spoke with a range of staff and spoke with patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice.

To get to the heart of patients' experiences of care 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. These groups are:

- Older people

Detailed findings

- 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)

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw a summary of significant events at the practice over the last year which demonstrated willingness by staff to report and record incidents.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every six months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. We saw how an incident involving a patient with reduced mental capacity had led to a review of the mental capacity of all patients registered at the practice with a learning disability. The practice had also met with the local authority staff member leading on care of vulnerable adults to discuss their response to the incident.

Both clinical and administrative staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at regular clinical meetings to ensure all clinicians were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

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

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children. The lead GP had received appropriate training to enable them to fulfil this role effectively. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. GPs were appropriately using codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and there was good liaison with partner agencies such as social services.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If a trained chaperone was required but not available, the practice's policy was to defer the examination if it was safe to do so.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system known as EMIS which collated all communications about the patient including scanned copies of communications from hospitals

Medicines Management

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

Are services safe?

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

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of the potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys were held securely. There were suitable arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness & Infection Control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy in place for needle stick injury.

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

Equipment

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

Staffing & Recruitment

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

Are services safe?

that the practice had not routinely checked that its nursing staff remained on the Nursing and Midwifery Council register each year. They should do so to ensure that practice nurses remain authorised to practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written into their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. The staff we spoke with and evidence we reviewed confirmed these discussions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us that they regularly discussed complex cases at their weekly clinical meetings.

Data from the local Clinical Commissioning Group suggested that the practice's performance for antibiotic prescribing compared slightly less well than with similar practices. The practice had met with the local pharmacy liaison officer to review and improve its performance in this area.

All GPs we spoke with used national standards for the referral of patients with suspected cancers. This ensured that such patients were referred and seen within two weeks. We saw minutes from meetings where reviews of elective and urgent referrals were made.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice showed us nine clinical audits that had been undertaken in the last year. The audit log showed the dates on which follow up audits would begin to complete the cycle. We reviewed two recent completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one audit examined the quality of care received by patients with multiple sclerosis. Following the initial audit the practice introduced a range of measures to improve patients' experiences. A follow up audit demonstrated a significant beneficial impact on the quality of care for patients with the condition. Other examples of clinical audits included an audit of anti-depressant prescribing and the screening of patients diagnosed with gout.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit of patients taking a particular medicine who had coronary heart disease or uncontrolled high blood pressure. The medicine had been identified as inappropriate for these patients in a recent safety update. As a result, the practice was able to prescribe an alternative medicine to affected patients.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 90% of patients with diabetes had an annual medication review. The practice met all the standards for QOF in diabetes, asthma, and chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they

Are services effective?

(for example, treatment is effective)

continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was very positive.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients or those with end of life care needs. The meetings were used to assess and review the risks to each patient on the register. The meetings were attended by district nurses, palliative care nurses and practice staff. Decisions about care planning were documented in a shared care record. Staff felt this system worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice made some referrals to secondary care using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). The practice had produced its own leaflet explaining the referrals system to its patients. The practice provided evidence that it supported choice for its patients at the point of referral.

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as EMIS was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. There was a system in place to scan paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The mental capacity of all the patients identified as having a learning disability had been recently reviewed following a serious incident with a patient with reduced mental capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the nurse was responsible for following-up patients who did not attend screening.

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

The practice offered a home monitoring service to people with high blood pressure. This service enabled patients to text their blood pressure readings taken at home to the surgery to help monitor their condition.

The practice had introduced 'dual clinics' so patients with more than one long term condition were assessed for all of them at a single appointment rather than being recalled separately for each condition.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. A survey of 150 patients was undertaken by the practice's Patient Participation Group and patient satisfaction questionnaires were undertaken by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 86% of patients described their overall experience at the practice as good or very good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 16 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

We were shown an example of a report on a recent incident when there had been a breach of a patient's confidentiality. Although the patient had not complained, the practice identified the breach itself and recorded the incident as a serious event. We saw that the actions taken as a result had been robust. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP was good at involving them in care decisions and 86% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 86% of patients said they were very satisfied with the care they received.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. We were told that one patient with a learning disability was seen by a GP at the end of a surgery when the practice was empty as this caused the person less stress.

The practice reviewed suggestions for improvements to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). We saw the practice's written response to a suggestion about how to improve the telephone system at the practice.

The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone interpreter services although these had not been used. The practice also had access to a translation service to translate medical letters received in a foreign language.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The surgery building was fully accessible to patients with mobility aids. The practice had its own wheelchair which was used to transport patients from a nearby car park if required.

The practice had a system in place to alert staff to any patients who might be vulnerable or who had special needs. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need as necessary.

Access to the service

Appointments were available from 8.30am to 11.30am and from 2.00pm to 5.30pm on weekdays. Patients were able to book appointments up to two weeks in advance by telephone or in person. GPs were able to book patients for follow up appointments up to eight weeks in advance. The practice aimed to be able to provide patients a routine appointment within 48 hours. At the time of our inspection, same day routine appointments were available. Patients could request a same day appointment if necessary. At the request of patients, the practice had introduced appointment booking up to one month in advance. This had increased the amount of patients failing to attend appointments significantly. After further discussions with patient representatives, the practice reverted to booking appointments two weeks in advance.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice opened for extended opening hours on one evening and one morning a week. This was particularly useful for patients with work commitments.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and

Are services responsive to people's needs?

(for example, to feedback?)

allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was a complaints leaflet in the waiting room and the process was also described on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the complaints log for the last twelve months and found that these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

We saw evidence of shared learning from complaints with staff at team meetings.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. The document said that the practice aimed to provide a supportive environment in which to work and delivered high quality health care through a well organised and happy team. The document was given to everyone who expressed an interest in working at the practice.

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

The practice was committed to becoming a progressive learning environment, wiling to embrace change but at the same time critically questioning and evaluating it.

There was a clear business plan in place although the partners recognised that this could do with updating following the recent recruitment of a new partner.

We saw evidence in meeting minutes that the practice was actively considering the impact on its services of a new housing development close by and was thinking about priorities for the coming year.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of these policies and procedures and found that they had been reviewed regularly and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. The partners also met weekly on a Tuesday morning. We saw that these meetings had a clear agenda and were fully recorded. The most recent meeting discussed chaperones, Ebola, training and rota issues.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed by clinicians at the practice.

The practice had completed a number of clinical audits, for example audits of anti-depressant prescribing and the screening of patients diagnosed with gout.

Leadership, openness and transparency

The staff could describe a clear leadership structure and knew who the lead clinicians were in each major area. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and staff induction policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The partners at the practice told us that they greatly valued the independence of their PPG and the constructive criticism it shared with them. They believed the PPG feedback provided the practice with an invaluable perspective in helping to provide patient care.

The practice had gathered feedback from patients through an annual patient survey organised by the PPG. The survey asked patients to rate and comment on their experience of each of the GPs in the practice. The results were shared with all patients and staff via notice boards and the practice web site.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training sessions where guest speakers and trainers attended. The practice was closed to patients one afternoon each month to allow dedicated time for staff training and development.

The practice was a well established GP training practice. Only approved training practices can employ GP Registrars and the practice must have at least one approved GP trainer. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP Registrar. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team. The practice also received medical students from Derby Medical School and regarded the training of future GPs as a core and invaluable activity.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and away days to ensure the practice improved outcomes for patients. For example, we were told that the practice had suffered a complete failure of its telephone system recently. We saw how the practice had recorded the incident as a significant event and had held a staff meeting to review how it had been handled.