Dr H D Nandha & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 04 November 2014 as part of our new comprehensive inspection programme. Overall this practice is rated as good.

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

Our key findings were as follows:

- Patients said clinicians treated them with compassion, dignity and respect and that they were involved in decisions about their care and treatment.
- Effective safeguarding policies and procedures were in place and were fully understood and implemented by staff.
- There was a multi-disciplinary collaborative approach to care and treatment with good use of multi-disciplinary meetings (MDT).
- New patient packs were translated into different languages to meet the needs of the individual patient.
- The practice was part of a scheme to avoid unplanned admissions. This focussed on coordinated care at home for the most vulnerable patients.
- Patients' spiritual, ethnic and cultural needs were considered and understood. The practice could access telephone translation services, face to face interpreters and multi-lingual staff.
- Leadership roles and responsibilities were being established and defined with clear lines of accountability.

In addition the provider should:

- Ensure that fire risk assessments for both sites include action plans and review dates.
- Ensure that clinical audit cycles are completed to demonstrate the impact achieved for patients and to facilitate on going quality improvement.
- All forms of patient information should be updated to provide current information to patients.

Summary of findings

- Arrange for reception staff to receive additional training and support to improve the service they deliver.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Infection prevention and control systems were in place with a designated infection control lead for the practice. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE guidance) was referenced and used routinely. 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. Staff had received training appropriate to their roles and further training needs had been identified and planned. Staff appraisals including a personal development plans were planned for late November 2014 with the new practice manager. We saw evidence of effective multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said clinicians treated them with compassion, dignity and respect and they were involved in care and treatment decisions. However some patients told us that reception staff did not treat them with respect. Accessible information was provided to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. In response to patients frequently being unable to access appointments and services in a timely way, the practice had reviewed the needs of their local population, and service improvements (including increased numbers of appointment) would take effect in June 2015. The practice were equipped to treat patients and meet their needs. Accessible information was provided to help patients understand the complaints system. There was evidence of shared learning from complaints.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver extended hours to the practice and so

Summary of findings

improve access for patients from June 2015. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the new management team. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and to identify risk. Some clinical audits should be repeated to ensure sustained improvement. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The appointment system was mainly by telephone and online appointments but older patients reported it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients from June 2015. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. Patients 65 years and over were offered an annual health check. All patients 75 years and over were allocated a named GP to offer continuity of care to ensure that their needs we're being met. Health care plans were provided for patients over 75 years, to help avoid unplanned admissions to hospital. The practice was responsive to the needs of older people, including offering home visits and access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Patients reported access was by telephone and online appointments, but it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients from June 2015. Data showed emergency processes were in place and referrals made for patients in this group who had experienced a sudden deterioration in health. When needed, longer appointments and home visits were available. All patients with a long term condition had a named GP and structured annual reviews to check their health and medication needs were being met. The practice had a high number of patients with diabetes and hypertension who required additional support and access to appointments. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver multidisciplinary support and care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Access was by telephone and online appointments, but patients reported it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients

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from June 2015. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice patient age profile is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. Access was by telephone and online appointments, but patients reported it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients from June 2015. The practice offered a choose and book service for patients referred to secondary services, which enabled them greater flexibility over when and where their test took place. NHS health checks were offered to patients over 40 years. The practice was proactive in offering health promotion and screening appropriate to the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Access was by telephone and online appointments, but patients reported it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients from June 2015. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their

Summary of findings

responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. The practice was meeting the needs of a high number of patients with diabetes and hypertension, with specialist clinics and appropriately trained staff.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Access was by telephone and online appointments, but patients reported it was difficult to access these appointments. The practice had a clear vision and strategy to deliver extended hours to the practice and so improve access for patients from June 2015.

People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had completed 95% of their mental health care plans. The practice had in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with 17 patients including one member of the Patient Participation Group (this includes representatives from various population groups, who work with staff to improve the service and the quality of care). We also received comments cards from a further nine patients. We also spoke with representatives of two care homes (for older people) where patients were registered with the practice.

Patients and representatives we spoke with confirmed that the practice needed to improve availability of appointments and waiting times to see doctors. They told us that it took too long to get through using the telephone system. Patients felt clinicians listened and were friendly and caring, and they felt treated with kindness and respect. Patients told us they were involved in decisions about their care and treatment, and were generally satisfied with the care and service they received. They were promptly referred to other services and received test results, where appropriate. However, most patients said reception staff did not put patients' needs first or treat them with respect.

Two care home representatives we spoke with praised the support received from the GPs, and the care and service patients received. They said that patients were promptly seen. However, care home staff confirmed patients had not received medication reviews and that patient care plans had not been developed in the past year. There was therefore a risk that these patients might not be receiving the care that was most appropriate to their needs.

Representatives of the PPG told us they worked in partnership with the practice. Patients were asked for their views, and their feedback was acted on to improve the service. The PPG carried out a patient survey in June 2014 and patients said that they were generally very satisfied with the care.

We looked at the 2014 national GP survey. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services. Areas where the practice scored highest included the involvement of patients in decisions about their care, treating patients with care and concern, and patients overall experience of the surgery was good. Areas for improvement included access to appointments, getting through to the practice by phone and waiting more than 15 minutes to be seen after their appointment time to be seen.

In response to the surveys, the practice had completed an action plan to address areas requiring improvement. The practice had confirmed there would be improvements around appointment availability from June 2015. Some changes were in place for the interim period to improve access for patients, with additional staff recruited and GPs working extended hours.

Areas for improvement

Action the service SHOULD take to improve

Ensure that fire risk assessments for both sites include action plans and review dates.

Ensure that clinical audit cycles are completed to demonstrate the impact achieved for patients and to facilitate ongoing quality improvement.

All forms of patient information should be updated to provide current information to patients.

Arrange for reception staff to receive additional training and support to improve the service they deliver.

Dr H D Nandha & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP and a Nurse.

Background to Dr H D Nandha & Partners

Evington Medical Centre provides primary medical services to approximately 10,000 patients in the area of Evington Leicester City. The practice provides a service to a group of patients aged between 25 and 55 years which are significantly larger than the national average. The number of patients with diabetes and high blood pressure is significantly higher at this practice than both the national and the CCG average. The range of services provided includes minor surgery, minor injuries, maternity care, blood testing, vaccinations, mental health, drug and alcohol services and various clinics for patients with long term conditions.

A new GP partnership was established in April 2014. The practice employs 16.5 whole time equivalent staff, including nine clerical staff, and 7.5 clinicians and a practice manager. The clinical team includes three male GP partners and two female salaried GPs, two practice nurses, three phlebotomists and a health care assistant. The practice provides 41 GP sessions a week. The practice opted out of providing the out-of-hours service.

The practice holds the following contracts: Personal Medical Services (PMS) to provide various locally agreed services. The practice had applied to become a training practice for trainee doctors from 2015.

This practice is supported by the Leicester City Clinical Commissioning Group (CCG).

Why we carried out this inspection

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

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 4 November 2014. During our visit we checked the premises and the practice's records. We spoke with various staff including, two practice nurses, three GPs, reception and clerical staff, and the business manager. We also received comments cards and spoke with patients and representatives who used the

Detailed findings

service, including one member of the Patient Participation Group (PPG). The PPG includes representatives from various population groups, who work with staff to improve the service and the quality of care.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4th November 2014. During our visit we spoke with a range of staff including GPs, receptionists, managers, practice nurse, administrative staff, health care assistant and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. In addition we carried out telephone interviews with two of the care homes that are served by the practice.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed the significant incident records and saw records were held of each event, the outcome and lessons learned. We reviewed minutes of meetings where incidents were discussed from the last six months**.** This showed the practice had managed incidents over time, and so could evidence a safe track record.

We reviewed safety records, incident reports and minutes of meetings for the last six months. The business manager and lead GP told us they worked closely with the Local Area Team (LAT) and the Clinical Commissioning Group (CCG) around some key incidents at the practice and had developed an action plan to ensure lessons were learnt, and improvements to safety were made.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last six months and these were made available to us. We saw clinical audits and found the re-audits to demonstrate change were not always completed. The practice should ensure that clinical audit cycles were completed to facilitate on going quality improvement. GPs and the business manager told us in the past the practice had not maintained effective record keeping systems. However this had changed with new systems introduced since April 2014 and more work was on going. At each clinical meeting significant events were discussed actions following on from past significant events were reviewed. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staffs including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available to staff. These were reviewed and progress monitored by the business manager. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example we saw for one incident, action taken as a result of information received back from laboratory results. The results had not been promptly passed onto a GP. The lessons learnt were that administrative staff were reminded to pass on any results from the laboratory to the GP at the earliest opportunity to ensure patient safety.

National patient safety alerts were disseminated by the business 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 aware of any relevant to the practice and where action needed to be taken. Many clinicians we spoke with referenced National Institute for Health and Care Excellence (NICE) guidance routinely.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children and vulnerable 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. Administrative staff had received safeguarding children and adults training online learning in 2014 at the practice. All GPs had completed level 3 training as part of their protected learning time (PLT) training with the Clinical Commissioning Group (CCG). Staff knew how to recognise signs of abuse in children and vulnerable adults. We found different versions of the safeguarding practice policies and procedures on the computer systems and in paper versions. The business manager confirmed safeguarding policies would be updated following on our inspection. However staff were aware of their responsibilities regarding information sharing and how to contact the relevant agencies in and out of hours. Contact details were available but needed updating to ensure they were easily accessible to staff.

The practice had a dedicated GP appointed as a lead in safeguarding children and vulnerable adults. They had been trained and we saw staff training records that confirmed staff had received could demonstrate the

necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff, health care assistants and some reception staff. Staff had undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

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

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The GP lead for safeguarding was aware of vulnerable children and adults. Records demonstrated good liaison with partner agencies such as the police and social services.

Medicines Management

We checked medicines stored in the treatment rooms, in the doctors bag, 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 actions to take in the event of a potential failure of telephone and power loss were described. We talked with the business manager around improving the recording of fridge temperatures as records showed on two occasions over two weeks both fridge temperatures had not been recorded.

We found one emergency medicine had been used and indicated with a sticker for replacement. There was no emergency medicine checklist and it was unclear if all the emergency medicines were present. Checks were scheduled every two to three months but there was no consistent evidence the checks had been undertaken. The business manager agreed to take steps to resolve this during the inspection. We received assurances after our inspection that the emergency medicines box had been reorganised and refilled and a medicine checklist in place with regular checks. 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.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, patterns of antibiotics, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw antibiotic prescribing audits for clindamycin, cephalosporin's, quinolones, macrolides and action to be taken with the patient's medicine regime to make improvements.

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. We found weekly vaccination audits took place to ensure safekeeping of medicines. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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.

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. We saw the privacy curtains around examination couches were identified for cleaning, but there was no system in place to ensure that curtains were

cleaned or changed regularly. The business manager confirmed the cleaning schedules would be improved. We saw a large stained area in one of the treatment room's floors. Following our inspection the business manager confirmed all carpets in treatment rooms would be replaced in May 2015. This would ensure floor surfaces were easier to keep clean and hygienic.

The practice did not have a staff lead for infection control. However doctors, nurses and administrators had undertaken regular infection control training. All staff received induction training about infection control specific to their role and thereafter annual updates. We saw the infection control policy and supporting procedures referred to monthly audits control of infection measures, and found the monthly audits had not taken place. The practice was not able to demonstrate there were systems in place to keep patients safe from the risk and the spread of infection. Following on our inspection a nurse was appointed as the new infection control lead at the practice and had received the relevant training.

Staff we spoke with said they were aware of infection control measures. For example, personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use to comply with the practice's infection control policy. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and alcohol gel was provided around the practice.

Minor surgery was carried out at the practice. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

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. The next portable appliance testing was due January 2015. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

Staffing & Recruitment

Staff recruitment records had been updated since April 2014. The business manager told us that prior to this staff recruitment records had not been fully maintained. 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. The business manager confirmed human resource protocols and procedures were still being developed.

Staff told us there were 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 business manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Staff told us when they were staff shortages they would cover each other, for example if someone was on leave or holiday.

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 but this was not current and needed updating. The practice had identified risks and these were discussed at GP partners' meetings and within team meetings. We found the practice had not established infection control audits to identify risks to patients and staff. The business manager agreed to address this aspect immediately and identified an infection control lead following on our inspection.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: For

patients with long term conditions there were emergency processes in place. Staff gave us examples of referrals made for patients that had a sudden deterioration in health. There were emergency processes in place for identifying acutely ill children and young people. Emergency processes were in place for acute pregnancy complications. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for patients receiving high risk medicines.

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 the procedure if an emergency took place for clinicians to begin emergency aid. The business manager agreed to ensure appropriate signs were displayed for the storage of oxygen and the defibrillator. (A defibrillator is equipment used to restart a person's heart in an emergency).

We looked at emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We looked at the emergency medication stock and found items were muddled and did not match with the emergency medicine list held with the stock. We also found one medicine had been removed and not replaced. Processes were also in place to check emergency medicines were within their expiry date and suitable for use, regular checks had not been maintained. The business manager agreed to carry out a risk assessment to identify a list of medicines that were suitable for the practice to stock, and to keep emergency medicines under review. Following on our inspection we received assurances this had been done. In the notes of the practice's incidents report meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, and infectious disease outbreak. The document also contained a list of the practice staff and their contact details and procedures to be put in place in case of an emergency.

We reviewed the fire risk assessments to maintain fire safety for each site. We found the fire risk assessments did not include action plans and review dates. The business managers agreed to update these and ensure the storing of medical gases were included in the fire risk assessments. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with said that they received updates relating to current best practice and the National Institute for Health and Care Excellence (NICE) guidelines electronically. The aim of these guidelines is to improve health outcomes for patients. Staff also told us that they discussed clinical issues and changes to practice at weekly meetings. The minutes of meetings we looked at confirmed this. The GPs had taken on lead roles in clinical areas such as diabetes, older people and palliative care. The practice nurses supported this work which enabled the clinicians to focus on specific conditions and to drive improvements.

We found from discussions with the clinical staff that they completed thorough assessments of patients' needs. Systems were in place to ensure that older people, those in vulnerable circumstances, with long term conditions and experiencing poor mental health received an annual health review, including a review of their medicines. A system was in place to recall patients for an annual review. We found one patient from the 17 patients we spoke with had not received a yearly medication review.

Regular multi-disciplinary meetings were held to review the health needs and care plans of patients who had complex needs and those receiving end of life care. These meetings were held every six weeks and included the lead GP, practice nurses, practice managers and care navigators. Care navigators were employed by Leicester City Council and funded by Leicester City Clinical Commissioning Group (CCG) in a joint commitment to improve and retain good general health and wellbeing in older patients over 75 years. The role of the care navigator were to support those patients over 75 years who identified as at the greatest risk of a hospital admission, so they maintained their independence and stayed in their own home's longer, and when it is appropriate and safe to do so.

The practice referred patients to secondary and other community care services. The culture was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Patients over 75 years had a named GP to ensure continuity of care and oversee that their needs were being met. The practice had a lower than average ageing population but the practice is meeting the needs of the aging population by delivering care plans tailored to their needs as they approach the end of their lives. Anticipatory care, medications and discussions with family members are met upon establishing care plans. The practice also offered home visiting services for those unable to attend the practice for both medical and social reasons.

Representatives from two care homes provided positive feedback about the GPs and the contact with support staff and felt patients received a satisfactory service. However they told us a person living in the care home's had not received medication reviews. GPs told us a review of medication would be undertaken when repeat prescriptions were arranged for the patient. Following on our inspection the GPs told us medication reviews would be planned annually with a visit to the care home to see the patient.

Patients with a learning disability were offered an annual health check, including a review of their medicines with the advanced nurse practitioner. The practice had completed 23 out of the 26 learning disability health checks. They told us they had until the 31st March 2015 to undertake the remaining health checks and made plans to contact those patients.

Staff worked closely with the local mental health team to ensure that patients experiencing poor mental health were regularly reviewed, and that appropriate risk assessments and care plans were in place. The practice had links with the crisis resolution teams, psychiatrists at Leicester Hospital, and a therapist who was based at the practice from the IAPT team (Improving access to psychological services). The practice had completed 95% of their mental health care plans.

The practice nurse told us they were responsible for immunisations of babies and children and worked closely with health visitors and midwifes. The practice offered a weekly midwife clinic for pregnant patients and health visitor clinics for those with younger children. All GPs completed both 24 hour and six week post natal checks. The practice reported good links with the Sure Start service.

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. Over half the 17 patients

Good

Are services effective?

(for example, treatment is effective)

we interviewed had been with practice over some time. The Patient Participation Group (PPG) member told us some of the doctors had been with the practice for 20 years and doctors knew their whole families and patients were treated fairly.

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 and adult protection alerts management and medicines management. The information staff collected was then collated by the business manager to support the practice to carry out clinical audits.

The team made use of audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. We saw that a system was in place for completing clinical audit cycles to provide assurances as to the quality of care. Various audits and reviews had been completed and were discussed at team-based meetings. For example, a review of prescribing antibiotics for clindamycin was completed but no further analysis or changes were suggested. A mortality review was carried out for every patient from April to June 2014. These clinical audit cycles did not to demonstrate the changes resulting from these that took place within the practice including a re-audit to provide assurances as to the quality of care, and to improve outcomes for patients.

Staff told us that the outcome of audits was communicated through the team and clinical meetings. Records showed that regular clinical meetings were held involving the GPs and nurse practitioner. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

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. Some GPs had special interests in diabetes, older peoples care and long term conditions. Most GPs had recently received training in diabetes and were working towards meeting diabetes patient targets. All GPs were up to date with their yearly professional development requirements and either had been revalidated, or had a date for revalidation. GPs are appraised annually and every five years undertake a fuller assessment called revalidation. Only when revalidation had been confirmed by NHS England could the GP continue to practice and remain on the performers list with the General Medical Council.

All managerial and administrative staff undertook annual appraisals around 12 months ago and were awaiting appraisals with the new practice manager in November 2014. Staff interviews confirmed that the practice were proactive in providing training and funding for relevant courses, for example GPs told us nurses were due to receive diabetes study leave to meet the needs of this patient group for the monthly diabetes clinic. Receptionists told us they received a wide range of training for example emergency first aid and were able to explain how they would deal with urgent care for chest pain for adults, and emergency care for babies and young children.

Working with colleagues and other services

We found that the practice worked effectively 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 hour's 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 auctioning 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.

The practice used several electronic systems to improve its communication with other providers. For example, there was a shared system with the local out-of-hours provider Prime care to enable patient data to be shared in a secure and timely manner. For example end of life care plans were shared with out -of -hours and the hospice team. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. Staff reported they had recently received training in Choose and Book training and systems were still new.

Multidisciplinary team meetings were held bi-monthly to discuss the needs of complex patients e.g. those with end of life care needs or children on the at risk register. The meetings were attended by social services representatives,

palliative care nurses, district nurses and community matrons. Decisions about care planning were documented in a shared care record. District nurses were invited but did not always attend. GPs felt this system worked well and was a means of sharing important information.

Information Sharing

A shared system was in place with the local out-of- hour's provider to enable essential information about patients to be shared in a secure and timely manner. The practice used SystmOne electronic system to coordinate record and manage patients' care. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference.

Electronic systems were also in place for making referrals. The Choose and Book system enabled patients to choose which hospital they wished to be seen in, and to book their own outpatient appointments.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to. We found that arrangements were in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements. Written consent was obtained for specific interventions such as minor surgical procedures, together with a record of the possible risks and complications.

Some clinical staff were aware of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements. They had not received formal training to ensure they understand the principles of the Act and the safeguards. The GPs told us on the day of our inspection they would make plans to provide Mental Capacity Act 2005 training for staff.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Patients who were part of the unplanned admissions enhanced service would have a care plan drawn up to ensure that their wishes were respected, including decisions about resuscitation and where they wished to die. This information was available to the out-of-hours service, ambulance staff and local hospitals and hospices. The GPs planned to review the arrangements for patients eligible for care plans at the care homes they had responsibilities for.

The end of life statistics demonstrated that GPs had been focusing on meeting this need, and had reviewed all of the end of life care patients. One GP reported this had been a very rewarding experience and had valued the time spent to improve standards of care for these patients.

Clinical staff understood the importance of determining if a child was Gillick competent especially when providing treatment and contraceptive advice. We saw an example where this had been applied in practice. (A Gillick competent child is a child under 16 who is capable of understanding implications of the proposed treatment, including the risks and alternative options).

Health Promotion & Prevention

We saw that a wide range of health promotion information was available to patients and carers on the practice noticeboards. The practice website was still being developed to include health promotion information. All new patients were seen by the practice nurse who completed a comprehensive assessment. This was to ensure staff obtained information about a patient's personal and medical history, and to ensure that any tests or reviews they needed were up-to-date. The new patient's registration packs were available in different languages for example Guajarati, Hindi and Slovakia. These were the commonly spoken languages by patients. The practice nurse told us they undertook health promotion with patients and discussed smoking cessation, weight loss and disease management issues.

The practice had a higher number of patients with diabetes and hypertension who were more prone to develop these conditions and required additional support and access to appointments. The practice provided an enhanced service for diabetes. There were dedicated clinics for patients using insulin with monthly diabetes clinics. Some staff had received additional training in these areas of health promotion.

The advanced nurse practitioner provided a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last

Good

Are services effective?

(for example, treatment is effective)

year's performance for all immunisations was above average for the area Clinical Commissioning Group (CCG) and there was a system in place for following up patients who did not attend.

The practice offered NHS Health Checks to all patients aged 40 to 75 years. Practice data showed that 408 patients in this age group had taken up the offer of the health check and 64 care management plans were in place. End of Life care plans were being completed with patients with 73 completed in September. The cervical smear uptake was meeting the 80 % target rate set by the area Clinical Commissioning Group (CCG). There was a system in place for following up patients who did not attend screening. The practice also had systems in place to identify patients who needed additional support, and were pro-active in offering help. All patients with a learning disability, experiencing poor mental health, over 65 years, with long standing conditions or aged 75 years were offered an annual health check, including a review of their medication. However representatives from the care homes did not confirm a yearly review of medication for their patients. The GPs agreed to change the arrangements for annual medication reviews for these patients.

The practice had identified gaps in patient groups for example young people in relation to chlamydia screening. The practise had planned to increase engagement with these groups and had already looked at ways of improving this. For example one of the doctors had discussed the promotion of chlamydia kits for young people with the reception staff taking the lead. Reception staff were working to weekly targets to reach this patient group.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 17 patients from younger people to older people. All but one patient said the care they received from the doctors were good and many commented that they had known the doctors for a long period of time and valued this. Patients' main issue was access to medical care. They felt the practice could improve the availability of appointments, waiting times for doctors, and being able to get through on the telephone system. Patients felt clinicians listened, and were friendly, caring, and were treated with kindness and respect. Patients told us they were involved in decisions about their care and treatment, and were generally satisfied with the care and service they received. They were promptly referred to other services and received test results, where appropriate. However, most patients said reception staff did not put patients' needs first or treat them with respect. We observed a receptionist talk with a patient with a query and wanted to book an appointment. Staff left the patient standing in the reception area for some time. We saw the patient was upset and not treated with courtesy and respect. The business manager agreed to immediately take action around this issue.

Two care home representatives we spoke with praised the support received from the GPs, and the care and service patients received**.** They said that patients were promptly seen. However, care home staff confirmed some patients had not received annual medication reviews.

Representatives of the PPG told us they had a commitment to the practice since 2012. They felt the practice had gone through a difficult time but had started to improve. The PPG were asked for their views and carried out a patient survey in June 2014, which patients completed. The report highlighted three main issues appointment availability, waiting times for doctors and getting through on the phone. There was a time frame on the action plan to take effect from 1 June 2015. Improvements would provide patients with extended opening hours at the practice and greater appointment availability. The PPG were aware of a number of complaints received about reception staff and had suggested staff training be provided for this staff group.

Patients completed CQC comment cards to provide us with feedback on the practice. We received nine completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and doctors and nurses were helpful and caring. One comment card were less positive about repeat prescriptions but there were no common themes to these. We also spoke with 17 patients on the day of our inspection. All told us they were satisfied with the care provided by clinicians 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. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations, and that conversations taking place in these rooms could not be overheard. We saw the receptionist offered patients the choice of seeing a male or female doctor.

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. Systems had been introduced to allow patients to approach the side of the reception desk or were able to access a consulting room to talk in private with staff. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Some receptionists told us they had received dealing with challenging patients training, and this had helped them deal with potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we received feedback from said that they felt listened to, and were supported to make decisions about their care and treatment. The 2014 national GP survey showed that 75 % of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Data showed us that 77 % of respondents to the GP patient survey stated that the last time they saw or

Good

Are services caring?

spoke to a GP, the GP was good or very good at involving them in decisions about their care. The practice's 2014 patient survey also showed that patients felt listened to, and involved in decisions.

The practice had signed up to the enhanced service to avoid unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. Clinical staff assured us that all patients assessed at high risk of being admitted to hospital, including certain elderly patients and people with complex needs or in vulnerable circumstances, had an anticipatory care plan in place to avoid this. The care plans included patient's wishes, decisions about resuscitation and where they wished to die. This information was available to the out of hour's service, ambulance staff, local hospitals and hospice teams. Care home representatives told us care plans were not available to patients in care homes served by the practice. GPs agreed to address these issues and arranged for care plans to be developed with the patient in person. The original form stayed with the patient.

The advanced nurse practitioner carried out an annual health review for patients with a learning disability at the end of the review the patient was provided with a health action plan which was agreed with them.

The practice serves a 71.61 % black minority ethnic group with 65 % Asian British. The most commonly spoken languages by patients were Gujarati, Hindi, English and Slovakian. We saw receptionists speaking in other languages to support patients. Staff had experience of accessing translation services for patients. Staff told us they had recently arranged for a Slovakian interpreter to attend the practice to assist a patient meeting the midwife.

Patient/carer support to cope emotionally with care and treatment

The practice is involved in the Palliative Care Gold Standards Framework. The Gold Standards Framework (GSF) is a way of working that involves GPs working with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for patients and their families at the end of their lives. Staff told us how the practice tried to record details of patients' next of kin and power of attorney details where appropriate.

Bereaved carers known to the practice were supported by way of a phone call from a GP, to determine whether they needed any practical or emotional support. We were unable to determine from discussions with patients or staff if GPs referred patients to a bereavement counselling service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients and representatives we spoke with confirmed that the practice needed to improve availability of appointments and waiting times to see doctors. They told us that it took too long to get through using the telephone system. Reception staff told us children and the elderly were seen as a priority. People with mental health needs would be seen by their named GP. Longer appointments were available for people who needed them and those with long term conditions.

The NHS Local Area Team (LAT) and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them to discuss local needs and service improvements that needed to be prioritised. The Patient Participation Group (PPG) minutes of meetings confirmed group members also attended relevant CCG meetings.

The practice had an active patient participation group (PPG) A patient participation group is a number of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patients' views and to work in partnership with the practice to improve common understanding and obtain patient views. We found the PPG was representative of the patient demographic. They were looking to be more representative of the patient population in terms of diversity and were seeking women and young people to join the PPG and had placed an advert in the practice newsletter. We spoke with representatives of the PPG who explained their role and how they worked with the practice. The practice website had also been redeveloped with involvement of one PPG member. Other members had analysed the patient surveys and developed an action plan in June 2014 around three main issues: Appointment availability, waiting times for doctors and getting through on the telephone. The service had made a proposal to provided extended opening hours. Once the plans were implemented patients access to the practice would be improved. PPG members confirmed there had been changes at the practice with staff leaving and new staff joining. They had just started to gain confidence with new doctors and developments at the practice.

The practice worked collaboratively with other agencies, regularly updated shared information such as special patient notes to ensure good, timely communication of changes in care and treatment. For example we saw how they worked with the unplanned admissions enhanced service to help identify those at risk of repeat hospital admissions, and were undertaking care planning including visiting patients where necessary.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice served a 71.61 % black minority ethnic group with 65 % Asian British. The practice had access to online and telephone translation services and GPs, nurses and reception staff spoke languages such as Gujarati and Hindi. The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

Access to the service

We spoke with 17 patients and they confirmed difficulty accessing appointments, including appointments not being available, long waiting times, and not seeing their preferred GP. Representatives from two care homes told us accessing appointments were difficult as the practice closed for 2.5 hours over lunch time every day (except Thursday). The practice opened Monday to Friday 9.00am to 6.00 pm with extended lunchtime closures and was closed on Thursday afternoons. Telephone consultations were provided with doctors and nurses and urgent appointments were available at set times in the morning and afternoon. Some appointments were available on line. The business manager told us about planned improvements to access from 1st June 2015. The practice would open earlier at 08.00am until 7.30pm three evenings a week and for two days close at 6.30pm. The practice would no longer close half day Thursdays. Once the plans were implemented patient access to the service would be improved. The practice had not been able to make the changes earlier due to a new GP partnership established and GPs retiring and the recruitment of locums.

Limited 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 through the website. We saw the practice website was still under construction. We found the

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patient Participation Group (PPG) had been working with the practice to complete work on the practice website but this had stopped, as the PPG member was unable to continue. If patients called the practice when it was closed including lunch times, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice was situated on the ground and first floor of the building with the majority of services for patients on the ground floor. Lift access was not available. Patients with health or mobility difficulties were seen on the ground floor. We saw that the waiting area were sufficient to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. The practice was an old building. There were access to toilets facilities but people with mobility difficulties may found the toilet areas difficult to access due to limited space.

The most commonly spoken languages by patients were Gujarati, Hindi, English and Slovakian. The staff group spoke different languages, and the practice provided formal translation services. The new patient's registration pack was translated into a number of different languages to meet the individual needs of the patient.

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. The business manager handled all complaints in the practice.

We looked at two completed formal complaints received by the practice around patient consultations with clinicians. These were received and investigated promptly and letters of apology sent to patients. Action was taken with the individual clinicians concerned. We saw a complaints audit from 01.04.13 to 31.03.14 which summarised complaints received. We found from audits that the practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from the two individual complaints had been acted upon.

We saw a suggestion box in the reception area which held two complaints. One was dated 6 October and so had not been dealt with in a timely manner. The business manager told us the suggestion box were checked daily and complaints were responded to informally face to face, by telephone or email but no records kept. Monitoring systems were not in place to record and report all concerns and complaints. We found the complaints policy and procedures were not current and needed review.

We saw that information was available to help patients understand the complaints system in a summary complaints procedure in the patients leaflet in the waiting area. 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 formal complaint about the practice.

We looked at NHS Choice website and found there were mixed comments about the practice. Over the last six months but there were more positive comments and the management team had responded to each comment and provided appropriate feedback.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's current business plan and part of the presentation to the Care Quality Commission (CQC). The practice had a strong commitment to providing personal care to their patients through their personal knowledge of patients and families they had known for years. The practice provided weekly practice newsletters. GPs told us since 7 April 2014 there had been a new GP partnership agreement established and there had been a new beginning for the practice. New locum insurance was established to recruit locums.

The practice had plans to improve patient access by extending appointment hours from 1st June 2015. When there will be with early opening at the practice from 08.00am and late night closing between 6.30 and 7.30pm Monday to Friday. We saw from business plans that the practice had experienced a turbulent past six months and had put extensive plans in place from April 2014 to June 2015 to make significant changes. A new GP partnership had been established and locum GPs were in post. There had been some redundancies and a new staffing and management structure were place, with one practice nurse recruited, two salaried GPs 1.4 full time equivalent and three administration apprentices in post.

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. However when we reviewed some of these we found they were not comprehensive or up to date. The business manager confirmed he was in the process of updating all the policies and procedures. The business manager had been in post since April 2014 and had found there were little to no policies and procedures available upon commencing work at the practice. He had taken steps to ensure protocols and procedures were established.

The practice held monthly governance meetings. We looked at minutes from the last meetings and found that performance, quality and risks had been discussed. However we found clinical audits were completed but did not always demonstrate sustaining improvement including an audit to ensure on going quality improvement.

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 at practice meetings and clinical lead meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead GP for safeguarding, training doctors, older people's care, and a lead GP and nurse for diabetic care. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings and with the business manager.

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example staff recruitment, induction policy, and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required. The business manager confirmed he was updating all the human resource policies and procedures

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) with six members and had carried out surveys and met regularly. The results from the last survey highlighted three main areas for improvement: - appointment availability, waiting times for doctors and getting through on the telephone. The practice had confirmed there will be improvements around appointment availability from June 2015. However some planned changes were in place for the interim period to improve access for patients. A GP had increased their hours and worked full time from November. The practice had recruited a salaried GP for six sessions, and additional staff were recruited to the clerical team. There were more telephone and face to face appointments available for patients. The Patient Participation Group (PPG) and management team were making plans to notify patients of the planned improvements in the service from June 2015. The improvements would be communicated to patients via SMS texting, alert emails, updates to the practice website and NHS Choices website.

Are services well-led?

Good

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

A minute of the PPG meetings were available on the website for 2013/14 but no later as the website was not up to date. We viewed minutes of a recent PPG meeting confirmed group members recommended reception staff received additional training and support. This was due to the number of complaints received on the NHS Choices website about the behaviour and attitude of reception staff. Most patients we spoke with said, reception staff did not put patients' needs first or treat them with respect. We observed a receptionist dealing with a patient who was told to wait and we saw they were left upset and not treated with curtsey and respect. The business manager told us after the inspection the reception staff group had received customer care training and new staff had joined this staff group.

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

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice and in a paper version in folders in staff areas.

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 appraisals were due to take place which included a personal development plan with the new practice manager. Staff told us that the practice was very supportive of training and guest speakers and trainers attended to speak with the staff groups.

The practice had applied to become a training practice for trainee doctors from 2015.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.