Dr Chittaranjan Pillai

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Chittaranjan Pillai on 11 March 2015. Overall the practice is rated as good.

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

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

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

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

Importantly the provider should:

- Introduce a system to ensure that GP prescription pads are handled in accordance with national guidance to enable them to be tracked through the

Summary of findings

practice. They should also introduce a robust system for the handling of manual repeat prescription requests to ensure there is an audit trail of the request and the changes made.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The infection control lead oversaw the cleanliness of the practice. There were enough staff to keep patients safe and appropriate recruitment checks were carried out for all new staff.

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. For example, the practice had achieved 96% of Quality Outcome Framework (QOF) points which was above the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. For example, 86% of respondents to the national patient survey carried out during January-March 2014 and July-September 2014 said the last GP they saw or spoke with was good at treating them with care. This was above the regional average. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that learning from complaints was shared with staff. Most patients we spoke with were satisfied with the appointment system however several patients commented on how difficult it was to get through to the practice on the telephone. Data from the national patient survey results carried out during January-March 2014 and July-September 2014 showed that that 81% of respondents described their overall experience of making an appointment as good or very good which was above the regional average.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular meetings which included governance matters. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very active within the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received inductions, one to one supervision, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked closely with the patient participation group (PPG) to run a monthly Age UK desk in the practice for older people and their carers in the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The lead GP led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Practice nurses had received the additional training they required for the review of patients with long term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of Accident and Emergency attendances. Immunisation rates were high for all standard childhood immunisations. For example, data from NHS England showed the practice had achieved 100% uptake in seven of the 18 routine pre-school immunisations. This was above the regional average. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice carried out cervical screening for women between the ages of 25 and 64 years. Their cervical screening uptake was 86% which was above the national target of 80%.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of vulnerable patients including those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had a personalised care plan in place. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. The PPG supported this work through the Age UK desk they ran in the practice by signposting patients who were socially isolated to support both within and outside of the practice. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All 38 patients with a diagnosis of dementia had a care plan in place that was reviewed annually. 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 told patients experiencing poor mental health how to access support groups such as MIND and SANE that provide care

Summary of findings

and emotional support for patients, their families and carers. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

All of the nine patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the four patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were mainly positive. Patients told us the staff were helpful, friendly, caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. On one of the comment cards we saw that a patient had found it difficult to register with the practice. We saw that the practice had raised this as a significant event and that relevant staff had been informed of the correct procedure to follow when patients register with the practice.

The results from the National Patient Survey carried out during January-March 2014 and July-September 2014 showed that 91% of patients said that their overall experience of the practice was good or very good. Eighty-six per cent of respondents would recommend the practice to someone new to the area. These results were above the Clinical Commissioning Group (CCG) regional average of 85% and 78% respectively. We looked at the results of the Family and Friends test which asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment. We saw that 89% of respondents said that they would recommend this practice.

Areas for improvement

Action the service SHOULD take to improve

The provider should introduce a system to ensure that GP prescription pads are handled in accordance with national guidance to enable them to be tracked through the practice. They should also introduce a robust system for the handling of manual repeat prescription requests to ensure there is an audit trail of the request and the changes made.

Dr Chittaranjan Pillai

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Chittaranjan Pillai

The practice of Dr Chittaranjan Pillai was originally founded in 1953 and moved to their current premises in 1988. The practice provides primary medical services to patients living in Mapperley, Nottingham and the surrounding suburbs.

A team of three GPs, a nurse practitioner, two practice nurses, a health care assistant, a practice and assistant practice manager and six receptionists and administrative staff provide care and treatment for approximately 5800 patients. One female and two male GPs provide care for patients at the practice. The practice does not provide an out-of-hours service to their own patients but patients are directed to the Nottingham Emergency Medical Service when the practice is closed.

We previously inspected this practice on 28 January 2014. At this inspection we found that the practice did not meet required standards in the care and welfare of people who use the service; supporting workers and assessing and monitoring the quality of service provision. We told the practice to take immediate action to address these issues.

We returned on 23 April and 24 May 2014 and found that required standards had still not been met for the care and welfare of people who use the service; supporting workers and assessing and monitoring the quality of service provision. In addition, we found that standards in staffing were also not being met. We met with stakeholders to discuss our concerns and to identify ways to support the practice in the changes they needed to make.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note 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

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?

Detailed findings

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

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

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with the chair of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice provided care to five care homes for older people and two residential homes for people with learning difficulties. We spoke with a representative from one of the care homes and a representative from one of the homes for people with learning difficulties. We also spoke with a health visitor and a practice liaison nurse (a PLN provides care and support to frail elderly patients). We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 11 March 2015 at the practice. During our inspection we spoke with the GP partner; a salaried GP; a locum GP; a nurse and a health care assistant; two receptionists; the practice and deputy manager; an administrator and nine patients. We observed how patients were cared for. We reviewed four comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, incidents, significant events, national patient safety alerts and comments and complaints received from patients. At our previous two inspections we found that significant events had not been recorded or investigated when issues had arisen. At this inspection we found that a process for reporting significant events had been introduced. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw minutes from practice meetings highlighting the importance of improving the reporting of significant events and we saw that staff had signed to say that they had read and understood this. When we reviewed recent incidents and complaints recorded at the practice, we identified that several of these were significant events. When we looked in the significant events records we saw that the practice had raised these as a significant event and that they were investigated accordingly.

The practice manager showed us the significant events that had been recorded and investigated for the previous eight years. We looked at those recorded over the last 12 months and saw that they had been fully investigated and where issues had been identified action had been taken. In the analysis of the significant event we saw that good practice was also identified and staff were recognised for this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw that significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at practice meetings and they felt encouraged to do so.

Staff used significant event forms and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor significant events. We tracked four incidents and saw records were completed in a comprehensive and timely manner. For example, following several complaints regarding a member of staff, a significant event form had been raised. We saw evidence that the member of staff had been provided with additional training to support them in the issues identified.

National patient safety alerts were disseminated electronically to practice staff by the lead GP in line with their practice safety alert policy. We saw that paper copies of these alerts were also kept in a designated file for all staff to refer to. We saw that there was a system in place for staff to sign to confirm that they had read and understood the concerns. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, a nurse told us about a recent alert they had received regarding the use of a blood sugar monitoring devise. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw minutes that confirmed this. We saw that medication audits had been carried out by the community pharmacist when alerts regarding certain medications had been received.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding children and vulnerable adults. 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 and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed on the walls of each treatment and consultation room and in the reception area where reception staff worked.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. We saw training certificates that demonstrated they had the necessary training to enable them to fulfil this role. All the staff we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern. Prior to our inspection, we spoke with a health visitor who worked with the practice. They told us they met

with either the practice manager or one of the GPs each week to discuss any concerns regarding children and their families registered with the practice. They told us that a formal multidisciplinary safeguarding meeting had recently been held to discuss the care of all the looked after children who were registered with the practice. This helped to ensure that this vulnerable group of patients received the most suitable care and support. The health visitor told us that there was also a system in place that ensured that the health visiting service were made aware of new children who registered with the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included alerts and information to make staff aware of any relevant issues when patients attended appointments for example, children subject to a child protection plan.

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed on the doors of the consultation and treatment rooms and on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. We spoke with one of the practice nurses who clearly described to us their role and responsibilities in protecting patients from the risk of abuse and knew what action to take if they had any concerns.

Medicines management

We checked the 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 that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. We saw daily schedules that demonstrated the practice staff followed this policy.

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. There was a system in place to check the expiry dates of the medicines kept in the GP bag used for home visits on a monthly basis. We saw that all the medicines were in date and fit for purpose.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular medication audits by the community pharmacist. The practice showed us four medication audits that had been completed by the community pharmacist to ensure medicines were prescribed in line with National Institute for Health and Care Excellence (NICE). Where issues had been identified, we saw that the practice had called patients in to review their medication.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely in a locked cupboard however GP prescription pads used for home visits were not handled in accordance with national guidance to track them through the practice.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice had a contract in place with an external cleaning agency to keep the practice clean and tidy. We saw there was a cleaning plan in place to inform cleaners of the areas they needed to clean. There were no daily cleaning records to demonstrate that this cleaning plan had been implemented however we saw that the cleaning company had carried out monthly cleaning audits to monitor the effectiveness of the cleaning. Where issues were identified we saw that cleaning staff were made aware of the improvements required. 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. Nursing staff had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that infection control audits had been carried out which included an audit of staff hand washing techniques. Any improvements identified for action were completed in a timely manner.

Good

Are services safe?

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if this occurred. 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 taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that appropriate staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that an in-house legionella risk assessment had been completed in September 2014 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. 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 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. We saw records that demonstrated all portable electrical equipment had been tested in January 2015 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in June 2014 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

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 that enough staff were 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.

At our last inspection we were not assured that the provider had undertaken a robust analysis of the availability of appointments so that it met the needs of its patients. At this inspection we saw that the practice had employed an advanced nurse practitioner to support the GPs in providing enough appointments for patients. The health care assistant had been given more hours to support the nursing staff. The practice was also in the process of applying to extend the practice from a single handed GP practice to a partnership between the existing single handed GP and the locum GP who worked for the practice. 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 keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that annual and monthly checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; lift maintenance checks by a suitable company; emergency lighting tests: an asbestos management survey and an assessment of the physical security of the building. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

Following our last inspection, the practice had invited the Medical Protection Society (MPS) to carry out a patient safety survey to support the practice in the identification of risks to patients. The MPS is a protection organisation for medical, dental and healthcare professionals. The survey covered the key areas of leadership and teamwork; communications; reporting and learning and resourcing and training. We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager described to us the changes they had been made following the survey. Examples included,

employment of additional staff, training in the management of complaints and increased practice and business meetings to improve communication between staff.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required. The health visitor we spoke with also confirmed this. The practice used a risk assessment tool to help them to identify and support the most vulnerable patients in their practice population. To support these patients, the practice worked closely with attached staff such as district nurses, palliative care nurses, the respiratory and diabetic nurse specialists and the patient liaison nurse (PLN). We saw minutes that demonstrated that these multidisciplinary meetings were held on a monthly basis to support these vulnerable patients. We spoke with the PLN prior to our inspection who told us the communication and engagement of the GPs at the practice was excellent.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly. We looked at a documented significant event that had occurred at the practice. It showed that staff had responded effectively to a recent medical emergency and that learning points had also been identified and shared with staff.

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 and anaphylaxis (a severe allergic reaction). Processes were also in place to check whether 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and the loss of domestic services. We saw that the business continuity plan included short, medium and long term plans to manage these situations.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We saw that there was a yellow triangle warning sign on the door of the room where the oxygen was stored to alert the fire service of the presence of oxygen if a fire were to occur at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that the GPs and nurses used clinical templates with NICE principles embedded in them. This assisted them to assess the needs of patients with long term conditions, older patients, patients with a learning disability and patients experiencing poor mental health. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The lead GP led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. We saw training certificated which demonstrated that practice nurses had received the additional training they required for the review of patients with long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and associate practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last 12 months. They were all completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We looked at the audits and saw that they were all medication audits carried out by the community pharmacist and the GPs had used these to audit and review the care and treatment their patients received. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding medicines used to treat pain or inflammation, a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine received the appropriate treatment to prevent the recognised side effects associated with its long term use. The first audit demonstrated that 23 patients were not receiving the appropriate treatment. Patients were called for a health and medication review with the GP. A second clinical audit was completed six months later which demonstrated that 14 of the patients reviewed had stopped taking the medication and the other nine were receiving the appropriate treatment to manage the potential side effects.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes. The results are

published annually. We saw that the practice met all the minimum standards for QOF in diabetes, asthma and COPD. This practice had achieved 96% of QOF points which was above the national average.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions were reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was used. We saw that there was a robust system in place for the issuing of electronic repeat prescription requests if a patient requested a change to their medication or for items that required reviewing. However, if a patient manually handed the request in to the practice where a change or review was required, staff attached written notes to the prescription request meaning there was no formal audit trail of the request for change or of any changes made.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses, specialist nurses and physiotherapists took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of 12 patients and alerts within the clinical computer system making clinical staff aware of their additional 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 courses such as annual basic life support. We saw that there was a training matrix in place that identified when staff had completed training the practice considered to be mandatory and when it was due to be updated. Due the difficulties of recruiting GPs in Nottingham, the practice had employed an advanced nurse practitioner (ANP) to support GP consultations. An ANP is a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of a general registered nurse. They are qualified to diagnose medical problems, order treatments, perform advanced procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines, and cervical screening.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this. Where necessary, we saw that the practice had worked with an external human resources company to support them in the management of a member of staff who had not met the required standards.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw 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. At our previous inspection we found that Accident and Emergency (A&E) discharge letters were not always reviewed by a GP before being filed in patients' records. At this inspection we saw that the A&E discharge letters were reviewed by the ANP before being filed. If the ANP had any concerns they informed the lead GP. We asked the lead GP how they had risk assessed that it was appropriate for the ANP to carry out this role instead a GP.

Good

Are services effective?

(for example, treatment is effective)

They told us that the ANP had received appropriate training up to post graduate degree level and had previous experience of triaging urgent calls within an out-of-hours service.

The practice was commissioned for the enhanced service, and had a process in place, to prevent avoidable hospital admissions. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice used a nationally recognised tool to identify its most vulnerable patients. We saw minutes confirming that monthly multidisciplinary team meetings took place to discuss these patients. We saw that 101 out of 104 admission avoidance care plans had been completed for vulnerable and frail patients registered with the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice used shared notes to share concerns with the local GP out-of-hours provider. The practice used the Choose and Book system to refer patients for hospital appointments. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned 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 Mental Capacity Act 2005 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. A practice nurse described to us the processes they followed when considering the best interest decisions made in giving a patient with a learning disability a 'flu vaccination. We saw that the correct procedures had been followed and were clearly documented in the patients' notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies when providing care and treatment to children. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

All new patients over the age of 16 who registered with the practice were invited for a routine health check with the health care assistant (HCA). The HCA told us that if they identified a health need they sign posted patients to services such as smoking cessation and weight management classes. The practice offered NHS Health Checks to all its patients aged 45-75 and travel vaccinations when needed. Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated that the practice was above the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations. For example, data from NHS England showed the practice had achieved 100% uptake in seven of the 18 routine pre-school immunisations. This was above the regional average.

There were systems in place to support the early identification of cancers. The practice carried out cervical smears for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 86%. The practice also proactively encouraged abdominal aortic aneurysm screening for men over 65 years of age. The Abdominal Aortic Aneurysm Screening Programme is a systematic national population-based screening programme that aims to reduce deaths from ruptured abdominal aortic aneurysms through early detection, appropriate monitoring and treatment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 117 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 143 patients undertaken by the practice's patient participation group (PPG) in November 2014. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The 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 GP patient survey showed that 91% of respondents said that their overall experience was good or very good and 86% of respondents would recommend the practice to someone new in the area. These results were above the regional Clinical Commissioning Group (CCG) average. The practice was also above the CCG regional average for its satisfaction scores on consultations with doctors and nurses. Ninety-four per cent of respondents said the GP was good at listening to them and 91% said the GP gave them enough time. Ninety-six per cent of respondents found the receptionists at this practice helpful. We looked at the results of the Family and Friends test which asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment. We saw that 89% of respondents said they would recommend this practice.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received four completed cards and saw that comments were mainly positive. Patients told us the staff were helpful, friendly, caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. One comment was less positive but the issue had already been addressed by the practice to prevent it from occurring again. We also spoke with nine patients on the day of our inspection. All of them 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 consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties but had systems in place to maintain patient's confidentiality. These included taking patients to private rooms to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the surgery for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. Staff told us of a recent incident that had occurred when a patient had been refused registration with the practice. We saw that the practice had clarified the registration process with all staff and that the patient had since been supported to register with the practice. There was evidence that learning had taken place as staff told us this had been discussed at a recent practice meeting.

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. They generally rated the practice well in these areas. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed 88% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were in line with or above the CCG regional average of 75% and 88% respectfully. The results from the practice's own patient satisfaction survey supported these findings.

Good

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. In addition, some members of staff at the practice were multi-lingual and spoke several Asian languages, Polish, Spanish and Italian.

We spoke with a practice liaison nurse (PLN) who worked with the practice to provide care and support to frail, older patients. They told us that the practice was proactive in identifying and communicating concerns about frail older patients registered with the practice. They told us that they worked with the practice to involve these patients in decisions about their care. Structured multi-disciplinary meetings were held at the practice on a four weekly basis to discuss the care of these patients. We saw minutes from meetings that confirmed this.

We spoke with a representative from a nursing home for older people. They told us that all the patients living there who were registered with Dr Chittaranjan Pillai had a care plan in place and received annual health reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNARCPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands.

A representative from a residential home for people with a learning disability confirmed that all the patients registered with the practice and who lived at the home had a care plan in place. They told us they also had a health action plan that had been agreed with the patient. A health action plan is a plan for young people or adults with learning disabilities that outlines their health needs and the support they need to stay healthy.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 86% of respondents to the national patient survey carried out during January-March 2014 and July-September 2014 said the last GP they saw or spoke with was good at treating them with care. This was above the regional average. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access 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.

The practice had supported the PPG to run a monthly Age UK desk for older people and their carers at the practice. The help desk was a free information service open to the public and held every second Wednesday of the month within the practice. The chairperson of the PPG told us that they had received positive feedback from patients who had accessed the service and that it had been nationally recognised in the Age UK 'Campaign to End Loneliness' progress report. The Age UK desk was operational on the day of our inspection. We observed that patients responded positively to this additional support.

We spoke with the chair of the PPG on the day of our inspection. They told us with the support of the practice they were extending the work of the Age UK desk to support patients who were socially isolated. They told us they had identified several socially isolated patients. They had plans in place to hold a monthly tea party at the practice to provide support and company to these patients.

We spoke with a health visitor who worked with the practice. They told us that children with long term

Good

Are services caring?

conditions were given a named GP to ensure that the child and their family received continuity of care. They also told us that the practice was proactive in alerting them to children and families that needed additional care and support. The health visitor told us that they met weekly with the practice manager or one of the GPs to discuss any concerns they may have about children registered with the practice.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. The lead GP showed us a copy of a letter they send to patients offering their support during this time. We saw a comment card from a patient who had received this support which was overwhelmingly positive.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice told us they had discussed challenges to the practice with the CCG to help them to identify the future needs of their practice population and how they will meet them. For example, a major local housing development of 850 homes is to be built near to the practice plus a new nursing home for 58 residents. This will put additional demand on the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The chairperson from the PPG told us how older patients and patients with long term conditions had spoken with the PPG about the difficulties they experienced getting to the hospital phlebotomy service to have blood taken for investigations. The PPG discussed this issue with the practice manager. On the day of inspection, we saw that the health care assistant now offered a phlebotomy service so that patients did not have to travel long distances to have their blood tests carried out. They told us that if necessary, the practice also provided a home phlebotomy service for patients who were housebound.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed the equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated by each member of staff.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground and first floors of the building with services for patients provided on both floors. There was a lift available for patients with mobility difficulties who were unable to walk up the stairs. There was an evac chair at the top of the stairs that could be used to transport patients downstairs in the event of a lift failure or fire. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included a disabled parking space; step free access to the front door of the practice; disabled toilets and a hearing loop for patients with a hearing impairment. If a patient was visually impaired, it was recorded in their records and the GP came out to fetch the patient to ensure they did not miss their appointment.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care. In addition, some members of staff at the practice were multi-lingual and spoke several Asian languages, Polish, Spanish and Italian.

The practice provided care and support to several house bound elderly patients and patients living in five care homes and two residential homes for patients with learning difficulties. Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice and a health action plan that had been agreed with the patient. A health action plan is a plan for young people or adults with learning disabilities that outlines their health needs and the support they need to stay healthy. If their learning disability prevented them from accessing the practice, a GP home visit was provided.

There were no homeless patients registered with the practice but the practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of culture, religion or sexual preference.

Access to the service

Appointments were available from 8 am to 6.30 pm on weekdays except Thursday when the practice closed at 1pm. When the practice was closed, patients were directed

Good

Are services responsive to people's needs?

(for example, to feedback?)

to Nottingham Emergency Medical Service (NEMS) for care and treatment. To meet the needs of working age patients, pre-bookable appointments were available twice a week from 7.30am with the advanced nurse practitioner and the lead GP provided telephone consultations between 6.30pm and 8pm on Tuesday evenings.

At our previous inspections we found that patients were unable to pre-book GP appointments. At this inspection we found that pre-bookable appointments were available one month in advance with the advanced nurse practitioner and GPs provided two pre-bookable appointments per GP a day. This meant that there were between four to six GP appointments per day depending on the number of GPs working. Patients could book these appointments over the telephone, face to face or on line. Most patients we spoke with were satisfied with the appointment system however several patients commented on how difficult it was to get through to the practice on the telephone. We saw that the practice had considered changing their telephone system but it had been considered too expensive. We looked at the national patient survey results published in January 2015 and saw that 81% of respondents described their overall experience of making an appointment as good or very good compared with the regional CCG average of 75%. We saw that the practice had carried out a supply and demand audit of appointments over a five month period. We saw that 95% of the time there were unused appointments at the end of each day meaning there were enough appointments to meet the needs of the practice population. However, it was not clear from the data which were GP appointments and which were appointments with the advanced nurse practitioner.

Comprehensive information was available to patients about appointments on the practice's website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed they were diverted to the NEMS. Information on the out-of-hours service was provided to patients in the practice and also on the practice's website.

Listening and learning from concerns and complaints

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

We saw that there was a practice leaflet informing patients how to complain both to the practice and to the other authorities such as the Care Quality Commission, NHS England and the Ombudsman. Patients we spoke with were aware of the process to follow if they wished to make a complaint. The complaints policy was also displayed on the practice website and in the reception area.

We looked at 12 complaints received in the last 12 months and found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated that complaints were a regular agenda item and that learning from them was shared with staff so they were able to learn and contribute to any improvement action that might have been required.

The practice reviewed complaints annually to detect themes or trends. We looked at their annual complaints review report for the previous 12 months. The practice had identified that there was a trend in the number of complaints regarding the communication skills of one of their members of staff. We saw that the practice had responded to this and arranged for the member of staff to receive additional training in communicating with patients.

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 vision to deliver quality care and promote good outcomes for patients. We saw that details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included, to help patients to manage their health and prevent illness, to act as the patient's advocate and to develop links with other health services by working closely with them. The lead GP told us there was a practice ethos to be a caring practice where patients' needs come first. Staff we spoke with shared and demonstrated this view.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We spoke with a representative from a care home for older people, a representative from a residential home for people with a learning disability, a health visitor and a practice liaison nurse (a PLN provides care and support to frail elderly patients) who confirmed that the practice had developed a strong working relationship with them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and staff demonstrated to us how they accessed them on the practice's intranet. We looked at nine of these policies and procedures and saw most of them had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, the lead GP was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at four audits and saw that they were medication audits supported by the community pharmacist. We saw that there were complete audit cycles which ensured that patients on certain medicines received the correct dosage and where issues were identified, changes to their medication was made.

At our previous inspection we saw that the practice did not have a system in place for identifying, recording and managing risks. At this inspection we saw that the practice had invited the Medical Protection Society (MPS) to carry out a risk survey to support the practice in the identification of risks to patients and the service. The MPS is a protection organisation for medical, dental and healthcare professionals. The survey covered the key areas of leadership and teamwork; communications; reporting and learning and resourcing and training. We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager described to us the changes they had been made following the survey. Examples included, employment of additional staff, training in the management of complaints and increased practice and business meetings to improve communication between staff. We saw that the risks were regularly discussed at practice and business meetings and updated in a timely way.

The practice held regular clinical, practice and business meetings. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that practice meetings were held monthly. Staff told us that since our last inspection there had been a change in the culture of the practice. They told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the internal computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and staff induction to the practice which were in place to support staff. We were shown the

Are services well-led?

Good

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

staff handbook that was available to all staff. We saw that the practice manager had used this handbook in regular one to one sessions with a new member of staff to support them in their induction to the practice.

Seeking and acting on feedback from patients, public and staff

In March and November 2014, the practice gathered feedback from patients through patient surveys into appointments, consultations with GPs and consultations with nurses. We looked at the results of these surveys and saw that when issues had been identified action had been taken in most cases. For example, the survey had highlighted the need for more pre-bookable appointments. We saw that an advanced nurse practitioner (ANP) had been employed by the practice to support this. An ANP a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of a general registered nurse. They are qualified to diagnose medical problems, order treatments, perform advanced procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice. Patients could pre-book appointments one month in advance with the ANP. GP pre-bookable appointments however, were restricted to two a day per GP providing four to six a day depending on how many GPs were working that day.

The practice had a very active patient participation group (PPG) that had been in place for five years. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG included one male and eight female representatives with an age range of 40 - 93 years. At our previous inspection the PPG told us that they did not feel valued by the practice. Prior to this inspection, we spoke with the chairperson of the PPG. They told us that support from the practice had significantly improved and they were now open and supportive to the PPG. They told us that the practice manager attended all of the PPG meetings and that the GP partner would be attending their annual general meeting.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and clinical supervision within clinical meetings. 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.

The practice had completed reviews of significant events and other incidents and shared the learning from these with staff at practice meetings to ensure the practice improved outcomes for patients. For example, one of the comment cards in our CQC comments box highlighted concerns a patient had regarding registering as a new patient with the practice. We saw that this had been raised as a significant event. One member of staff told us how learning from this incident had been shared with staff at the practice meeting. They told us the process of supporting new patients had been clearly discussed at the meeting to prevent the incident occurring again.

We saw minutes from clinical and practice meetings that demonstrated the practice had discussed complaints after they had happened to learn and improve the service they provided to patients. Complaints were a standard agenda item on the practice agenda. We saw that complaints were reviewed over time and trends identified. For example, complaints from patients regarding a particular member of staff's communication skills had been raised several times. We saw that the member of staff had been provided with communication skills training.