Dr Webb and 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Webb and Partners on 28 January 2015. Overall the practice is rated as good.

Specifically, the practice was rated as good for providing safe, effective, responsive and caring services. In addition, it was rated as good for providing services to the six population groups.

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

- Patients expressed high levels of satisfaction with the care and service they received. They said that they were treated with kindness, dignity and respect and were involved in decisions about their care and treatment.
- The practice was accessible and well equipped to meet patients' needs.
- Patients were able to access care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day.
- Procedures were in place to help keep patients safe and to protect them from harm, although recruitment procedures required strengthening.
- Patients felt listened to and able to raise concerns about the practice. Concerns were acted on to improve the service.
- Staff felt valued, well supported, and involved in decisions about the practice. They were supported to maintain and develop their skills and knowledge to enable them to carry out their work effectively.
- The practice had undergone various changes in the last six months since two partners had retired and a new GP had been appointed. Staff told us that the changes were well managed.
- The staff team were committed to new ways of working to ensure the service was well-led. Systems were in place to assess and monitor the quality of services and to drive improvements.
- The practice obtained and acted on patients views. The Patient Participation Group (PPG) worked in partnership with the practice to improve the services for patients.

Summary of findings

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

Importantly the provider should

- Strengthen the recruitment procedures to ensure the required employment checks are obtained for all staff. Also, develop the induction programme to take account of specific roles to enable new staff to carry out their work.
- Ensure the clinical audit programme includes more completed audits, to demonstrate the changes made to patients care and treatment.
- Ensure that all patients on the palliative care register are regularly discussed with relevant professionals, to aid communication and ensure they receive coordinated care.
- Ensure that information available to patients enables them to understand the complaints process.

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

GOOD

The practice is rated as good for providing safe services. Arrangements were in place to ensure that the practice was clean, safe and adequately maintained. Systems were also in place to keep patients safe and to protect them from harm. Risks to patients were assessed and appropriately managed. The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Learning took place and appropriate action was taken to minimise incidents and risks. There were enough staff to keep people safe.

Are services effective?

Good

GOOD

The practice is rated as good for providing effective services. The majority of staff had worked at the practice a number of years, which ensured continuity of care and services for patients. Staff worked closely with other providers and relevant professionals to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. Clinical audits were used to improve the outcomes for patients, and provide assurances as to the quality of care. However, the audit programme needed to include more completed audits to demonstrate the full extent of improvements made to patients care and treatment. Staff were supported to maintain and develop their skills and knowledge to enable them to carry out their work effectively.

Are services caring?

Good

GOOD

The practice is rated as good for providing caring services. Patients described the staff as friendly and caring and said that they were treated with dignity and respect. Patients were involved in decisions about their care and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and condition. We observed that patients' privacy, dignity and confidentially were maintained; staff were respectful and polite when dealing with patients.

Are services responsive to people's needs?

Good

GOOD

The practice is rated as good for providing responsive services. The services were flexible and were planned and delivered in a way that

Summary of findings

met the needs of the local population. Patients were able to access care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day. There was a culture of openness and people were encouraged to raise concerns. Patients concerns and informal complaints were listened to and acted on to improve the service.

Are services well-led?
GOOD

Good

The practice is rated as good for being well-led. The practice obtained patients views to improve the service. The practice had a clear vision to deliver high quality care and services for patients, which was shared by the staff team. All staff had clear roles and responsibilities to ensure that the service was well led. Staff felt valued, well supported, and involved in decisions about the practice. Systems were in place to assess and monitor the quality of services and to drive improvements.

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

Good

The practice is rated as good for the care of older people. Patients over 75 years had an allocated GP to provide continuity of care to ensure their needs were being met. They were also offered an annual health check. Care plans were being put in place for patients with complex needs and at risk of unplanned admissions to hospital, to help them remain at home. The practice worked closely with other services to enable patients to remain active and reduce the risk of falls. The practice kept a register of older people who had complex needs and requiring additional support. Regular multi-disciplinary meetings were held to discuss their needs. Carers were identified and supported to care for older people. Home visits were carried out for elderly housebound patients. Flu, pneumococcal and shingles immunisations were offered to elderly patients.

People with long term conditions

GOOD

Good

The practice is rated as good for the care of people with long-term conditions. All patients were offered an annual health review including a review of their medicines, to check that their needs were being met. When needed, longer appointments and home visits were available. Where possible, patients' long term conditions and any other needs were reviewed at a single appointment, rather than having to attend various reviews. Home visits were carried out for housebound patients. Patients were educated and supported to self-manage their conditions. A local diabetes service provided review and advice for patients with diabetes. Patients with certain respiratory conditions had a 'rescue pack' containing essential medicines to take in response to acute symptoms.Flu, pneumococcal and shingles immunisations were offered to patients.

Families, children and young people

GOOD

Good

The practice is rated as good for the care of families, children and young people. Priority was given to appointment requests for babies and young children. Systems were in place for identifying and following-up children at risk and living in disadvantaged circumstances. The practice worked in partnership with midwives,

Summary of findings

health visitors and school nurses to meet patients' needs. Immunisation rates were high for virtually all standard childhood immunisations. Children were able to attend appointments outside of school hours via the 'hub' service held at the local community hospital. Patients were referred to the Child and Adolescent Mental Health Services, where appropriate. The practice provided maternity care and family planning services. Teenagers had assessed the surgery as a Teenage Friendly practice. The practice provided advice on sexual health for teenagers, and screening for sexually transmitted infections. Chlamydia testing kits were available in the patients' toilets.

Working age people (including those recently retired and students)

Good

GOOD

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients were offered same day appointments or telephone consultations. Vulnerable patients were invited to attend an annual health review. The practice worked with multi-disciplinary teams in the case management of vulnerable people to ensure they received appropriate care and support. When needed, longer appointments and home visits were available. Carers were identified and offered support, including signposting them to external agencies. A monthly clinic was held to provide advice and support to patients who were deaf or had a hearing impairment.

People whose circumstances may make them vulnerable

Good

GOOD

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Summary of findings

People experiencing poor mental health (including people with dementia)

GOOD

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of patients experiencing poor mental health. Patients were offered same day appointments or telephone consultations. Counselling services were held at the practice. Patients also had access to 'Talking Mental Health Derbyshire', which offered a range of therapies. Patients were invited to attend an annual health check. The practice worked with mental health services to ensure that appropriate risk assessments and care plans were in place, and that patients' needs were regularly reviewed. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. Patients had access to a local memory clinic. The practice screened appropriate patients for dementia, which resulted in early referral and diagnosis where dementia was indicated.

Summary of findings

What people who use the service say

Prior to the inspection, we received comment cards from 43 patients. During our inspection we spoke with seven patients. Patients expressed high levels of satisfaction about the care and services they received. Twelve patients described the service as excellent, brilliant or outstanding. Patients told us that they were involved in decisions, and were able to access care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day.

Patients said that the premises were clean and accessible. They described the staff as professional, friendly, caring, and helpful, and felt that they were treated with dignity and respect. They also said that they felt listened to, and able to raise any concerns with staff if they were unhappy with their care or treatment at the service.

We also spoke with senior staff at two care homes where patients were registered with the practice. They were complimentary about the services, and said the practice staff were responsive to patients' needs. They also felt that the practice was well managed.

The practice obtained patients' views to improve the service. The practice had a Patient Participation Group (PPG). A PPG includes representatives from the population groups who work with the practice staff to represent the interests and views of patients to improve the service. The practice and the PPG issued an annual satisfaction survey to patients. The results of the 2014 survey, which 74 people completed, showed high levels of satisfaction. We spoke with a member of the PPG. They told us that they had agreed the action points from the last satisfaction survey, and that the practice staff worked with them to further improve the service.

We looked at the national GP survey results for January 2015, which 104 patients completed. In most areas the practice scored significantly above the local Clinical Commissioning Group (CCG) average for example, 92% described their experience of making an appointment as good, 96% found it easy to get through to the practice by phone and 97% found the receptionists helpful. The practice scored below the local CCG average in the following areas: 42% felt that they normally don't have to wait too long to be seen and 43% said that they usually wait 15 minutes or less after their appointment time to be seen.

Areas for improvement

Action the service SHOULD take to improve

- Strengthen the recruitment procedures to ensure the required employment checks are obtained for all staff. Also, develop the induction programme to take account of specific roles to enable new staff to carry out their work.
- Ensure the clinical audit programme includes more completed audits, to demonstrate the changes made to patients care and treatment.
- Ensure that all patients on the palliative care register are regularly discussed with relevant professionals, to aid communication and ensure they receive coordinated care.
- Ensure that information available to patients enables them to understand the complaints process.

Dr Webb and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a second CQC inspector and a member of staff from NHS England who observed the inspection.

Background to Dr Webb and Partners

Dr Webb and Partners is a partnership between two GPs providing primary medical services to 3,770 patients. The practice area includes Ilkeston, Cotmanhay, Kirk Hallam, Shipley, West Hallam and Stanton By Dale in Derbyshire and Awsworth, Babbington village, Cossall and Trowell in Nottinghamshire.

The practice population group includes: 11.5% of patients over 75 years of age, 12.5% aged between 65 and 75 years, 59.5% are aged between 18 and 65years and 6.5% are under 5 years old.

The staff team includes eight administrative staff, a practice manager, a nurse practitioner, a practice nurse, a health care assistant and three GPs (one salaried and two partners). All staff are female except for one GP.

Dr Webb and Partners has a single branch at Ilkeston Health Centre, South Street, Ilkeston, Derbyshire DE7 5PZ.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services. The practice opted out of providing the out-of-hours services to their own patients. This is covered by Derbyshire Health United Limited provider.

The Care Quality Commission (CQC) intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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, including Healthwatch and the

Detailed findings

overview and scrutiny committee. We also obtained feedback from senior staff at two care homes where patients were registered with the practice, and two external professionals who worked closely with the practice.

We carried out an announced visit on 28 January 2015. During our visit we checked the premises and the practice's records. We spoke with the practice manager, the nurse practitioner, healthcare assistant, three GPs and reception and clerical staff. We also received comment cards we had left for patients to complete, and spoke with patients and a member of the Patient Participation Group (PPG).

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

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

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

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

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, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff had reported a problem with the fridge temperature used for storing vaccines. Appropriate action was taken to replace the vaccines and to minimise further incidents.

A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. Records showed that safety incidents and concerns were appropriately dealt with.

Staff told us that national patient safety alerts were discussed at staff meetings. Although the minutes of meetings we reviewed did not reflect this. The practice manager agreed to address this.

We found that risks to patients and staff were assessed and appropriately managed. We reviewed safety records and incident reports for the last two years. These showed that the practice had managed these consistently over time and so could show evidence of a safe track record. Certain incident reports were not dated. The practice manager agreed to address this issue.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. Records showed that patients received an apology when mistakes occurred. We saw that a system was in place for reporting, recording, investigating and monitoring significant events and incidents. Records were kept of incidents that had occurred during the last five years.

We looked at seven recent significant events. These were completed in a timely way, and generally included a concise summary of action taken to avoid re-occurrences and lessons learnt. Although, not all incident analysis records included the same level of detail. The practice manager agreed to address this issue.

Records showed that the findings and learning from significant incidents were shared with staff at team meetings, and that appropriate learning and improvements had taken place. For example, one significant event involved an incident concerning a controlled drug prescription (medicines that require extra checks and special storage arrangements because of their potential for misuse). Following the incident, the systems were strengthened to provide an audit trail to show that prescriptions had been issued and collected.

The significant events log did not include the date in which all incidents occurred. The practice manager agreed to include this information.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received recent safeguarding training specific to their role. For example, the GPs had completed level 3 children's training and relevant vulnerable adults training.

Records we looked at showed that staff had received appropriate training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and who to speak to in the practice if they had a safeguarding concern. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Contact details were accessible.

A system was in place to highlight vulnerable patients on the practice's electronic records, including children and young people on a child protection plan. The alert system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when patients attended appointments or contacted the practice, including a child's next of kin.

We were shown the system in place to highlight children under five years who attended A&E. The practice also received details from A& E after a child had been seen, and the GPs followed through these to determine any patterns or concerns.

The GP partners told us that notifications and concerns regarding domestic violence were now attached to patient's records. We were shown examples of this.

Good

Are services safe?

However, notifications of domestic violence were not always shared with the practice. They had requested that relevant professionals including the midwife and health visitor attached to the practice promptly shared this information, and they had agreed to send a task or telephone the practice to notify them of incidents.

One of the GP partners was the lead for safeguarding vulnerable adults and children. They had the necessary training to enable them to fulfil this role, and were aware of vulnerable children and adults registered with the practice. The practice worked with relevant professionals and partner agencies such as the local authority, to share essential information about vulnerable patients. Essential information was recorded in patient's records.

The safeguarding lead told us that in view of changes to the health visitor linked to their practice, they did not currently meet regularly with them to discuss and review safeguarding issues and vulnerable patients to help ensure they were safe and protected from harm. Following the inspection, we received confirmation that the practice had set up an initial meeting, with a view to meeting regularly.

A chaperone policy was in place, which was visible to patients attending the practice.

The practice manager told us that certain reception staff would act as a chaperone if nursing staff were not available. Staff we spoke with recalled having received some training to carry out chaperone duties some time ago. They were aware of their responsibilities, including where to stand to be able to observe the examination. However, records were not available to show that all relevant staff had received training to carry out chaperone duties effectively. The practice manager agreed to arrange for relevant staff to attend appropriate training.

We received assurances that relevant staff that carried out chaperone duties had a satisfactory disclosure and barring (DBS) check. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children.

We saw that patients' individual records were managed in a way to keep people safe. The practice's electronic system held essential information about patients' health and welfare securely.

Medicines management

Several patients told us that the system for obtaining repeat prescriptions worked well, to enable them to obtain further supplies of medicines. Senior staff at two care homes where patients were registered with the practice also said that the system worked well.

Arrangements were in place to ensure that medicines were managed safely and appropriately. We found that medicines were stored securely. Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines were within their expiry date and appropriate for use.

All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations. A policy was in place for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

The nurses administered vaccines using guidelines in line with national guidance and requirements. We saw evidence that the nurses had received appropriate training to administer vaccines. A member of the nursing staff had recently qualified as an independent prescriber. They told us that they received regular supervision and support in their role, as well as updates in the specific clinical areas, which they prescribed.

A repeat prescribing policy was in place, which was followed by the practice. Following a recent event involving a controlled drug prescription (medicines that require extra checks and special storage arrangements because of their potential for misuse) the systems for managing these had been strengthened, to provide an audit trail to show that they had been issued and collected.

A system was also in place for updating changes to repeat prescriptions. For example, on receipt of information from secondary care following a patient's discharge from hospital. An alert system was also in place to highlight patients on the practice's electronic records that were not safe to collect their prescriptions, or required their medicines dispensing in compliance aids to ensure they were taken appropriately.

Arrangements were in place to ensure the security of prescription forms. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

Are services safe?

A system was in place to oversee the management of high risk medicines, which included regular monitoring in line with national guidance. The practice worked with the Clinical Commissioning Group (CCG) medicines team, to ensure that medicines were managed safely. A member of staff from the medicines team carried out regular audits, to check that patients' medicines were prescribed appropriately.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning schedules were in place and records were kept, to ensure that the practice was clean and hygienic. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness.

The nurse practitioner was the lead for infection control who had undertaken training to carry out this role. They informed us that all staff received induction training about infection control specific to their role and received refresher updates.

Staff we spoke with confirmed that they had received the training. They also had access to the policy and procedures to enable them to apply 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.

The infection control policy required that staff completed an audit to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. The last completed audit was dated 14 December 2014. The report showed high levels of compliance, and that various remedial actions had been completed. The remedial actions that had yet to be completed did not include timescales for completion. The infection control lead assured us that these would be completed by the end of June 2015.

We saw that an infection control risk assessment had also been completed which, included control measures in place to minimise identified risks. The findings were shared with the staff team.

The infection control policy and procedures were detailed and up-to-date. These were issued on 10 December 2014 and were due to be reviewed in November 2016. The procedure file was available to staff.

We checked various stock supplies of clinical and medical devices such as dressings and syringes; all items were in date. Records showed that relevant staff checked the supplies at regular intervals to ensure they remained in date, were sealed where required, and were used appropriately.

A policy was in place relating to the immunisation of staff at risk of the exposure to Hepatitis B infection, which could be acquired through their work. Records were available to show that all relevant staff were up to date with their vaccinations, and had received a 5 yearly booster, where required.

The practice had a policy for the management and testing of legionella (bacteria found in the environment which can contaminate water systems in buildings). Records showed that a Legionella risk assessment had been completed. The required control measures and checks outlined in the report were being carried out to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Further equipment including spirometers (used to help test how well a patient's lungs work) had recently been purchased. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this.

A schedule of testing was in place to ensure that all equipment was routinely tested. We also saw evidence that relevant equipment was routinely calibrated to ensure it was working properly, including weighing scales, blood pressure measuring and ear syringe devices.

Staffing and recruitment

The practice had a recruitment policy that largely set out the standards it followed when recruiting new staff. The practice manager agreed to update the policy to detail all stages of the process and information required by law.

We reviewed the files of the three most recently employed staff. We found that robust recruitment procedures were generally followed in practice to ensure that new staff were suitable to carry out the work. However, the files did not contain all information required by law prior to staff commencing employment at the practice, to ensure they were suitable to work with vulnerable adults or children.

Good

Are services safe?

For example, the files did not contain satisfactory information about any physical or mental health conditions, which are relevant to the person's ability to carry out their work. The practice manager agreed to update the staff files to ensure they contained the required information.

One staff file did not contain evidence that a satisfactory disclosure and barring (DBS) check had been obtained. We saw that a DBS application had been submitted. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children. Following the inspection, we received written assurances that a satisfactory DBS check had been obtained.

We noted that two files contained a brief record of the interview carried out. This did not show that robust procedures were followed. The practice manager agreed to address this issue. We will review recruitment procedures at the next inspection.

A policy was in place for checking nurses and GPs qualifications and continued registration to practice with their relevant professional bodies. Although records were not available at the time of the inspection, to show that one of the nurse's and GPs registration to practice had been confirmed. Following the inspection, we received confirmation of this. The practice manager had strengthened the systems to ensure that checks were completed to identify all clinicians remained registered to practice.

Most of the staff had worked at the practice for a number of years, which ensured continuity of care and services. Staff told us about the arrangements for ensuring sufficient numbers and skill mix of staff were available to meet patients' needs. They covered each other's absences to ensure enough staff were available.

In the last six months two partners had retired and the practice had appointed a fulltime salaried GP. There were plans to appoint another partner. The actual number of GP sessions had not changed.

Staff considered that there were enough staff to maintain the smooth running of the practice and to keep people safe. Records showed that the staffing levels and skill mix were in line with planned requirements.

Monitoring safety and responding to risk

The practice had a health and safety policy, which staff had access to. There was also a health and safety representative. The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, equipment, medicines management, staffing and dealing with emergencies.

Records showed that the equipment was regularly tested and maintained to ensure it was safe to use. Arrangements were also in place to ensure that the premises were appropriately maintained and safe.

We saw that staff were able to identify and respond to risks to patients including deterioration in their well-being. For example, procedures were in place to deal with patients that experienced a sudden deterioration in health, and for identifying acutely ill children to ensure they were seen urgently. Arrangements were also in place for patients experiencing a mental health crisis, to enable them to access urgent care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw a live example of this during the inspection. The clinical staff were called to attend to a person who had fallen outside the practice. The response by the clinical staff was excellent. They immediately attended the person with the emergency equipment. Having assessed the person was safe to move, they were moved into the practice to receive further treatment and support, until the ambulance staff arrived.

Records showed that all staff had received recent 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). Staff we spoke with knew where the equipment was located, and records showed that it was checked regularly.

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

Good

Are services safe?

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily running of the practice. Actions were recorded to reduce and manage the various risks. The practice worked in partnership with the adjoining surgery to ensure appropriate support and arrangements were in place to enable the continuation of services following an incident.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Arrangements were in place to ensure that staff were up to date with fire training.

Staff we spoke with knew what to do in the event of a fire. Records showed that staff practised an annual fire drill. The manager planned to provide two fire drills a year as advised in the fire risk assessment, to ensure that all staff knew what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they received effective care and treatment. Comment cards we received from patients, and feedback from senior staff at two care homes where patients were registered with the practice also supported that the services were effective.

The GPs and nurse practitioner we spoke with outlined 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. They told us that they discussed new guidelines and agreed changes to practice at clinical team meetings. We saw evidence of this.

The GPs and nurses provided lead roles in certain clinical areas, including infection control and family planning. However, the development of lead roles was limited in view of the size of the practice and recent GP changes.

There was a holistic approach to meeting patients' needs, which was driven by all staff at the practice. The practice had an established staff team who knew their patient groups well. They worked closely with local services and other providers to meet patients' diverse needs, and help reduce the risk of unplanned admissions to hospital. This enabled patients to remain at home, where possible.

We found from our discussions with the GPs and nurse that they completed thorough assessments of patients' needs, and provided care and treatment in line with NICE guidelines. They were referred appropriately to other services on the basis of need.

Management, monitoring and improving outcomes for people

Staff had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management.

The GPs told us clinical audits were often linked to medicines information, safety alerts or as a result of information from the quality and outcomes framework (QOF). We saw evidence of this.

QOF is a voluntary incentive scheme for GP practices in the UK, which rewards practices for managing some of the most common long-term conditions and for applying preventative measures. The QOF data for 2013 to 2014 showed that the practice achieved 98.2%, which was above the local and national average for other practices. The practice scored over 90% in all clinical areas, except for learning disabilities. Action was being taken to improve this score.

We saw evidence that audits were used to improve the outcomes for patients, and provide assurances as to the quality of care.

We looked at eight clinical audits that had been undertaken in the last two years. Although only one of these was a completed audit where the practice was able to demonstrate the full extent of changes resulting since the initial audit. For example, an initial audit was completed of patients with coeliac disease, which resulted in increased monitoring of associated health risks and awareness of the illness. A further audit completed six months later showed improved care and monitoring of the patients' condition. One GP partner told us they planned to develop the audit programme to include more completed audits.

We did not see evidence to show that minor surgical procedures were audited to evaluate the effectiveness of the diagnosis, treatment, and the incidence of complications. However, the practice manager told us that the GP partner, who carried out the minor surgery, had completed an audit in the last 12 months prior to them retiring. They agreed to forward us details of this.

Staff told us that the outcome of audits were communicated through the clinical team meetings, which enabled the staff to discuss clinical issues to drive improvements in care. They spoke positively about the culture in the practice around audit and quality improvement. There was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. As a result of this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Good

Are services effective?

(for example, treatment is effective)

The evidence we saw showed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

The majority of staff had worked at the practice a number of years, which ensured continuity of care and services. The practice had a motivated and established team with appropriate knowledge, skills and experience to enable them to carry out their roles effectively. This ensured continuity of care and services.

The practice was advertising for a part-time business manager. This was a new post to support the running of the practice to ensure the services were effective.

Records we looked at showed that staff had attended various training relevant to their role, including mandatory courses such as infection control, fire safety and basic life support. The practice closed for half a day most months to enable all staff to receive time for learning. Staff were also being supported to complete various on line learning via the internet.

Staff told us they had received appropriate induction training and support to enable them to carry out their work. We noted that new staff completed a brief induction programme that was not relevant to specific roles, to ensure that all staff were properly trained.

Staff told us they worked well together as a team. They also said that they were supported to share best practice, and further develop their skills and knowledge to meet patients' needs and provide high quality care. For example, records showed that the healthcare assistant had received relevant training to carry out ECG's (an ECG machine records the rhythm and the electrical activity of a patient's heart), blood tests, minor dressings and new patient health checks.

The member of staff had been assessed competent to carry out the above tasks. Records had been completed to support this. The health care assistant said that they had also attended a recent course on wound care and weight loss to meet patients' needs. They were also being supported to attend training on spirometry (lung function tests) and diabetic foot checks to further develop their role and meet patients' needs.

The nurse practitioner also told us they were supported to develop their skills to meet patients' needs. They had recently completed training and qualified as an independent prescriber, which enabled them to prescribe certain treatments. They also carried out specific roles such as administrating vaccines, cervical cytology and managing patients with long-term conditions. They were able to demonstrate that they had received appropriate training and updates to undertake such roles.

Records showed that staff received supervision through peer support and regular team meetings they attended. They also received an annual appraisal to review their performance and learning and development needs. Two staff files we checked supported this.

The GPs demonstrated that they were up to date with their yearly professional development requirements, and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

Our findings showed that the practice worked closely with other service providers and relevant professionals, to meet patients' needs and enable them to remain at home, where possible.

Records showed that community team meetings were held every fortnight, to discuss the needs of adult patients with complex needs or at risk of harm or unplanned admission to hospital, including frail elderly persons. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

The above meetings were attended by a district nurse, social worker, physiotherapist, community matron, care co-ordinator and other professionals, where appropriate. Decisions about patients' needs were documented in a shared care record. Staff felt this system worked well and that the forum provided a means of sharing important information.

The practice also worked closely with the 'single point' access team to help reduce unplanned admissions to hospital and enable patients to remain at home. The team enabled patients to access same day physiotherapy, emergency respite care or increased home care support.

Good

Are services effective?

(for example, treatment is effective)

The GPs were also able to admit patients directly to the two medical wards at Ilkeston Community Hospital, where required. They were contracted to carry out two ward rounds a week at the Community Hospital, which provided continuity of care for their patients.

Discussions with staff and records we reviewed showed that the practice staff shared information about vulnerable children with their health visitor, midwife and school nurses.

In view of changes to the health visitor linked to the practice, the safeguarding lead did not meet regularly with them, to review safeguarding issues and vulnerable patients. Following the inspection, we received confirmation that the practice had set up an initial meeting with their health visitor, with a view to meeting regularly.

We found that the practice held a palliative care register, and worked closely with relevant professionals to support patients with end of life care needs. Staff told us they discussed various patients on the register and their families, at regular internal meetings. This was documented in the patient's notes. Patients with palliative care needs at risk of unplanned admission to hospital, or recently discharged from secondary care were also reviewed at the community team meetings. The above arrangements did not include all patients on the palliative care register.

Information sharing

Staff used SystmOne electronic patient record to coordinate, document and manage patients' care. They also used electronic systems to communicate with other providers. The practice received test results, letters and discharge summaries from the local hospitals and the out-of-hours services both electronically and by post.

A policy was in place outlining the responsibilities of relevant staff in passing on, reading and acting on any issues arising from communications with other providers on the day they were received. A system was in place to coordinate records and manage patients' care, and enable essential information to be shared in a secure and timely manner. All staff were trained to use the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference.

We saw that patients test results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly seen, coded and followed up by the GPs, where required. Electronic systems were in place for making referrals to ensure these were made promptly.

The practice was signed up to the electronic Summary Care Record, which provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. For example, for patients receiving end of life care the notes would include essential information about their needs, medicines and wishes in regards to their care and treatment.

Various policies and information was currently stored in different places including in paper form. There were plans to further develop the IT systems to enable the practice to store all policies and information on a central shared drive to aid communication and the management of documents.

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.

Clinical staff told us that they obtained patients' informal consent before they provided care or treatment. There was a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment.

Staff gave examples of how patients' best interests were taken into account if a person did not have capacity to make a decision. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans, with their involvement. Clinical staff demonstrated a clear understanding of Gillick competencies. (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).

Clinical staff were aware of the Mental Capacity Act 2005, and the Children Acts (1989 and 2004) and their responsibilities to act in accordance with legal requirements. We received assurances that all staff had received relevant training to ensure they understood the key parts of the legislation, and how they applied this in their practice. The practice manager agreed to update the training records to show this.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

We saw that a wide range of health promotion information was available to patients and carers

on the practice's website, and the noticeboards in the waiting area. The information was well set out. For example, there was a specific notice area for infant and juniors, women's health, sexual health, carers and the Patient Participation Group.

New patients completed a form, which provided some information about their lifestyle and health. It was also practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted that the clinical staff used their contact with patients to help improve their health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years, alcohol screening, and advice and support with weight loss and smoking cessation. Chlamydia testing kits were available in the patients' toilets.

The practice also offered NHS Health Checks to all its patients aged 40-75, which included essential checks such as blood pressure, weight and cholesterol, and screening for conditions such as atrial fibrillation (a condition that causes an irregular heartbeat) and diabetes.

The practice was involved in a wide range of screening programmes including bowel, breast and cervical screening. Data showed that the practice achieved a high level of cervical smear tests; to date this was 86.6% There was a system in place for following-up patients who did not attend health screening.

Patients had access to a local memory clinic. The practice screened appropriate patients for dementia, resulting in early referral and diagnosis where dementia was indicated. The practice was able to arrange a specialised X-ray scan prior to a patient being seen in the memory clinic for the first time, which helped to form a diagnosis with other supporting results.

The practice offered a range of immunisations for children, as well as travel vaccines, shingles and flu vaccinations in line with current national guidance. The 2013 to 2014 data for all childhood immunisations showed that the practice was achieving above the average vaccination rate compared to the Clinical Commission Group (CCG) rates, except for Meningococcal C vaccination. A system was in place for following up patients who did not attend for their immunisation vaccine.

Data showed that the practice had 845 patients aged 65 years and over, of which 635 had received an influenza immunisation so far in the 2014/2015 period to reduce the risk of them developing flu.

Effective systems were in place for identifying patients who needed additional support, and the practice was proactive in offering this. For example, the practice kept a register of all patients with a learning disability, experiencing poor mental health, those in vulnerable circumstances, with long term conditions and older people. They were offered an annual health check, including a review of their medicines.

Staff were proactive in supporting patients to manage their health needs and live healthier lives.

Data showed that a high percentage of patients with long term conditions had received an annual review. For example, 81% of patients with chronic obstructive pulmonary disease (a term used for people with chronic bronchitis, emphysema, or both conditions) had been reviewed so far in the 2014/2015period.

Patients were educated about their conditions to improve their compliance and self-management. For example, 10 out of 11 patients diagnosed with diabetes in the last 12 months, had been referred to a diabetic education and management course.

There was a high incidence of obesity and Type 2 diabetes in the area where the practice was located. The CCG had commissioned a diabetes service, in which a consultant, diabetic nurse and dietician provided review and advice for patients. Clinics were held alternatively at one of the local practices and at Ilkeston Community Hospital. The service also provided a weekly educational meeting for clinical staff to discuss topics around the management of diabetes. We saw evidence that the practice staff worked closely with the diabetes service, to review patients whose condition was not well controlled.

Patients with certain respiratory conditions such as chronic obstructive airways disease had a 'rescue pack', containing

Good

Are services effective?

(for example, treatment is effective)

essential medicines to take in response to acute respiratory symptoms. The pro-active management of patients' symptoms had helped reduce the need for emergency admission to hospital.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with and comment cards we received expressed high levels of satisfaction with the care provided by the practice. Patients described the staff as professional, friendly, helpful and caring, and felt they were treated with dignity and respect. They also said that they felt listened to and that their views and wishes were respected. Several patients referred to the care and treatment as 'first class'.

Senior staff at two care homes we spoke with where patients were registered with the practice, also said that the staff were caring and considerate, and treated patients with respect.

Staff and patients highlighted various examples of staff providing a caring approach. For example, a staff member went out to talk with a patient who was struggling to walk in the car park. The patient admitted that they were experiences difficulties in coping at home. With the patient's agreement they were referred to the community team for support.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a suitable room. We observed this and noted that conversations could not be overheard. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 national patient survey, which 104 patients completed, and the practice's satisfaction survey, which 74 people completed. The results showed high levels of patient satisfaction with how they were treated; this was with compassion, dignity and respect.

The national patient survey showed that 95% of people said that the last GP they saw or spoke with was good at giving them enough time, 93% said they were good at treating them with care and concern, 97% said that they were good at listening to them and 100% said that they had confidence and trust in them. Also, 97% said that the last nurse they saw or spoke to was good at treating them with care and concern and 97% said that they were good at listening to them.

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, who would investigate these.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said that health issues were discussed with them and they felt involved in decisions about the care and treatment they received. They also said that they felt listened to, and supported by staff, and had sufficient time during consultations to make informed choices about the treatment they received.

The 2015 national survey results showed that 89% of patients said that the last GP they spoke with or saw was good at involving them in decisions about their care, and 96% were good at explaining treatment and results. In addition, 89% said that the last nurse they saw or spoke with was good at involving them in decisions about their care, and 95% were good at explaining treatment and results. These results were higher when compared to the local Clinical Commission Group average.

Clinical staff told us that patients at high risk of unplanned admissions to hospital, including elderly patients and those with complex needs, or in vulnerable circumstances, had a care plan in place to help avoid this. The care plans included patient's wishes, including decisions about resuscitation and end of life care. We saw evidence of this.

Patient/carer support to cope emotionally with care and treatment

The most recent data available showed that patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with during the inspection and comment cards we received also praised the emotional support provided.

Good

Are services caring?

Patients told us that were supported to manage their own care and health needs, and to maintain their independence, where able.

A carer's notice board was displayed in the patient waiting room, and an information pack was also available. The practice website also told patients how to access a number of support groups and organisations. Carers' details were included on the practice's computer system, to alert staff if a patient was also a carer to enable them to offer support.

Citizen's advice held a weekly surgery at the practice, which patients and carers had access to.

Staff we spoke with demonstrated that importance was given to supporting carers to care for their relatives, including those receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from their usual GP, to determine whether they needed any practical or emotional support. One patient we spoke to who had had a bereavement confirmed they had received this type of support, which they had found helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice was responsive to their needs. One example given was a GP had worked closely with a patient's consultant to ensure their long-standing medical condition was well controlled during their pregnancy.

The practice knew the needs of their patient population well. There was a holistic and pro-active approach to meeting patients' needs, which was driven by all staff at the practice.

The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other services. For example, the practice had a slightly higher percentage of patients with diabetes than the national average. The clinical staff worked with the local diabetes service, in which a consultant, diabetic nurse and a dietician provided advice and support to patients to enable them to be treated locally.

The practice engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the local practices decided through the CCG that each practice would provide primary medical services to a specific care home, to improve the care and outcomes for patients.

We spoke with senior staff at two care homes where patients were registered with the practice, including the main care home the practice supported. They told us that the practice was responsive to patients' needs.

As part of the enhanced services, the main care home was visited twice a week by an advanced nurse practitioner attached to the CCG, who worked closely with patients' GPs. The GPs also had regular contact with the care home and visited patients as required. This was a new initiative. The pro-active approach provides continuity of care and ensures that patients are regularly reviewed, to help prevent unplanned admissions to hospital and health issues from becoming more serious.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. Staff told us they operated a patient list culture, accepting patients who lived within their practice boundary. The practice also provided temporary registration and treatment, where required. For example, Ilkeston town held an annual fair close to the practice. Staff who worked on the fairground were supported to register as temporary patients and receive treatment.

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.

A monthly clinic was held to provide advice and support to patients who were deaf or had a hearing impairment. Patients were also able to make appointments using text messaging.

The services for patients were located on one level. The premises were refurbished in 2014, and were accessible and adapted to meet the needs of people with disabilities. As part of the recent refurbishment programme, improvements had been made to make it easier for patients in a wheelchair, and mothers with young children in a pushchair to access the premises.

Electronic couches had been provided in all consulting rooms, which elderly patients and those with disabilities found beneficial. A member of the Patient Participation Group (PPG) told us the group were consulted about the refurbishment programme, and improvements to the internal access.

The practice had a 95% white British population. We saw that a translation service and information was available in various languages, for patients whose first language was not English.

Staff we spoke with said that they had attended equality and diversity training. They also said that equality and diversity issues were discussed at team meetings. However, the records we looked at did not show that all staff had attended the above training. The practice manager agreed to ensure that all staff attended the training.

Access to the service

Patients told us they had very good access to urgent and non-urgent appointments. They said that they were usually able to get an urgent appointment to see a GP the same day or were offered a telephone consultation, where needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The latest national GP survey showed that 96% of people who completed this found it easy to get through to this surgery by phone. Also, 95 % were able to get an appointment to see or speak to a clinician the last time they tried.

Patients were able to book an appointment in person, by telephone or text. Non-urgent appointments could be pre-booked two weeks in advance. The practice was looking to extend access to appointments by enabling patients to book these on line.

We found that the appointment system was flexible to meet the needs of patients. Staff offered patients a choice of appointments to meet their needs, where possible. We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who were not well enough to attend the practice. Staff added patients who needed to be reviewed urgently to the appointments to be seen that day, or arranged for a call back from a GP, where appropriate.

Where possible, telephone consultations and home visits were undertaken by a GP who knew the patient best. Longer appointments were also available for people who needed them, including those with long-term conditions, a learning disability or experiencing poor mental health.

Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. When closed, an answerphone message gave patients the telephone number they should ring depending on their circumstances.

The practice was open from 8 am to 6.30 pm Monday to Friday. GP appointment times were from 9.am to 12.00 midday and from 2.30 to 5.30 pm.

The practice was not contracted to provide extended opening hours. However, in December 2014 a 'hub' service was established at the local Community Hospital, where appointments were available three evenings a week. This enabled patients to see a local GP outside of the practice's opening hours.

From January 2015 the 'hub' service was extended to five evenings a week and Saturday and Sunday mornings. This enabled children and young people to attend appointments outside of school hours. It also enabled patients who worked and those unable to attend in the day to attend in an evening or weekends.

We saw that the information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. The practice manager told us that they regularly reviewed the appointment system and telephone response times, to ensure it met the demands on the service. We saw evidence of this.

Listening and learning from concerns and complaints

Patients said they felt listened to and were able to raise concerns about the practice. Not all patients were aware of the process to follow should they wish to make a complaint, but they said that they had not had cause to do so. We noted that limited information was available to patients to help them to understand the complaints procedure on the practice's website and at the surgery.

The complaints procedure was not entirely in line with current guidance and the NHS procedure for GPs in England, as it stated that patients could initially complain to the practice or the Clinical Commissioning Group (CCG). All references to the CCG required removing as they do not have a role in the NHS complaints procedure. The practice manager agreed to address this.

A system was in place for managing complaints and concerns. The practice manager was responsible for handling complaints with involvement of the GPs. They told us that most concerns were dealt with informally and were promptly resolved. Staff recorded concerns and complaints in a separate record to the patient's notes.

Records showed that six informal complaints received in the last 12 months were promptly dealt with and resolved. These were included as significant events, to ensure that appropriate learning and improvements had taken place. The practice manager confirmed that the surgery had not received any written/formal complaints in the last 18 months. Therefore, an annual review had not been completed to identify any patterns and trends. In the absence of recent formal complaints we were unable to establish if complaints were acknowledged, investigated and responded to in line with the practice's policy.

Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that any concerns were shared with staff at team meetings, and were acted on to improve the service for patients. Records we looked at supported this.

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 improve the health and wellbeing of patients by providing a high quality service. Staff we spoke with knew and understood the values and aims of the service, and what their responsibilities were in relation to these.

Records showed that regular business meetings were held, where future plans were discussed. Two GP partners had retired in the last six months and a new fulltime salaried GP had been appointed, with a view to possibly becoming a partner. The partners told us that in view of the changes, the practice was undergoing a settling period. The current focus was more on short to medium term plans for future development.

The partners had set out various plans for 2015, such as developing the IT systems to improve efficiency and access to information. Staff we spoke with were aware of the future plans, and were committed to new ways of working to ensure the service was well-led.

Governance arrangements

We found that effective systems were in place for gathering and reviewing information about the safety and quality of services that people received. Systems were also in place for identifying, recording and managing risks. The practice had undergone various changes in the last six months since two partners had retired and a new GP had been appointed. Staff told us that the changes were well managed.

Records showed that regular business meetings were held to discuss the practice's finances, governance, performance and future plans. Senior managers demonstrated a commitment to continually improve the services. For example, a part-time business manager was being recruited. This was a new post to support the day to day running of the practice and to drive improvements.

Systems were in place to ensure that staff received essential information and were informed of changes. The practice had a range of policies and procedures in place to govern the practice. Some were available electronically and some in paper form. There were plans to store all policies on a central IT shared drive to improve access to the information.

A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and that these were shared with staff. Eight key policies we looked at had been reviewed recently and were up to date. We found that the policies were followed in practice.

The practice had a programme of clinical audits, to provide assurances that patients were receiving appropriate care and treatment. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The 2013 to 2014 data for this practice showed it was performing above national and local averages in virtually all clinical areas assessed. Records showed that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a leadership structure which set out staff's roles and responsibilities to ensure that the service was well managed. For example, the senior nurse was the lead for infection control, one of the GP partners was the lead for safeguarding and family planning, whilst the other GP partner was the lead for governance and undergraduate training. All staff we spoke with were clear about their own roles and responsibilities, and felt that the practice was well led.

Staff also said that they felt valued, well supported, and involved in decisions about the practice. They enjoyed their work and the morale was good. The culture of the organisation was open, and staff felt able to raise any issues with senior staff as they were approachable. The practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it.

Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through surveys, comments and complaints.

The practice had an active Patient Participation Group (PPG), which is group of patients who work with the practice to represent the interests and views of patients, to improve the service provided to them. We spoke with two

Are services well-led?

Good

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

members of the PPG. They told us that certain members attended a networking meeting every other month with 12 other local practices to share ideas and ways of improving the services. The group had tried to enlist further members to represent all patient groups including younger people. No younger persons had expressed an interest in joining.

The Patient Participation Group (PPG) worked in partnership with the practice to improve the services. Suggestions and feedback from patients were acted on. For example, a practice newsletter had been introduced, the telephone system had changed, the premises had been adapted to meet the needs of people with disabilities and access to the car park had improved.

The PPG were involved in developing the 2015 patient questionnaire, which was issued to patients in January. The results had yet to be reviewed. The results and actions from the 2014 patient survey were reviewed and agreed with the PPG. The results showed that 72 out of 74 patients, who completed the survey, said that they would recommend the practice to other people.

Discussions with staff and records we looked at showed that the practice obtained feedback from staff through team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the quality of the services provided.

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

Management lead through learning and improvement

Staff told us that they were supported to acquire new skills and develop their knowledge to provide well-led services. For example, the senior nurse had recently completed training and qualified as an independent prescriber, which enabled them to prescribe certain treatments. Records showed that staff received on-going training and development, and an annual appraisal to enable them to provide high standards of care.

The practice offered placements for medical students from Nottingham and Derby Universities. At the time of our inspection, the practice had two first year and two second year students attached to the practice. One of the GP partners was the lead for students in training. The practice also offered placements for nursing students, which the senior nurse supported.

The practice had arrangements for identifying, recording and managing risks. Records showed that incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions, learning and improvements had taken place to minimise further occurrences.