Whitley Road Medical Centre

Quality Report

Whitley Road Medical Centre
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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?	Outstanding
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

We carried out an announced comprehensive inspection at Whitley Road Medical Centre on 3 June 2015

Overall the practice is rated as good. We found the practice to be outstanding for providing effective services and good for providing safe, well led, caring and responsive services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Open access surgeries operated each morning until 10.30am. All patients who arrived at the surgery during this time period were seen by a GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and it was trying to establish an effective Patient Participation Group (PPG).
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of supportive team working across all roles.

We also saw areas of outstanding practice:

Summary of findings

- The practice was committed and supportive to improving palliative care services to its patients and was working very closely with the palliative care teams to make sure patients received appropriate end of life care.
- The practice actively screened patient blood test results to identify those that were pre-diabetic. Those identified were invited in to an appointment to discuss the risk of developing diabetes and review lifestyle choices to mitigate this risk.
- The practice initiated insulin therapy on-site, instead of having to attend the local hospital.
- The practice was supporting patients with 'Self Care' which is an initiative to build confidence and knowledge for patients to manage their own minor ailments and so reduce the frequency of appointments with a GP.

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

Importantly the provider should:

- Ensure a formalised plan of action to monitor, review and reduce the rate of prescribing hypnotics if appropriate is recorded and implemented.
- Ensure a standardised approach to recording written consent from patients before any minor surgery procedure is undertaken.

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. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example; the practice carried out monthly clinical meetings where significant events were reviewed. A six monthly audit and review of these was undertaken to help clinical and practice based learning. All staff had received safeguarding training and staff we spoke with were aware of the safeguarding vulnerable adults and children policies in place. The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use. The practice had emergency equipment and medication available including oxygen. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Patient's needs were assessed and care was planned and delivered in line with current legislation and best practice guidance. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles, 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 and worked closely with other health care professionals and GP practices to promote and improve the quality of cancer and end of life care. Practice nurses took lead responsibility to support patients with long term conditions and relationships were established with diabetic nurse specialists and the Acute Respiratory Assessment Service at the local NHS hospital. In addition, the practice was proactive in supporting patents by using local and national initiatives such as Fit 4 Work and Self Care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a

Summary of findings

patient-centred culture and found evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of 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 NHS England Area Team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was clear on the areas where it wanted to improve the service it provided. Patients said they liked the open access appointment system, that they found it easy to get through on the telephone to make a planned appointment, and they usually got an appointment with their preferred named GP. Despite the limitations of the building the practice facilities were used effectively and it 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.

Are services well-led?

Good

The practice is rated good for providing well led services. It had a clear 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 management. Management systems were well established and effective. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice kept a register of those patients aged 75 and had allocated them a named GP. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. The practice had a higher than average number of patients with long standing health conditions (68.3% compared to the Clinical Commissioning Group and England averages 55% and 54% respectively). Patients with long term conditions were supported by a healthcare team that was trained, used good practice guidelines and were attentive to changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The practice had established systems to identify and support patients who were pre-diabetic, and a practice nurse was trained to initiate insulin therapy in diabetic patients. In addition, the practice staff had received training to promote and encourage self care by patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Childhood Immunisation rates were good for all standard immunisations. Twice weekly baby clinics were held and systems were in place to ensure children who missed their immunisations were reminded to attend clinic. Clinical staff were knowledgeable about the needs of their patient population and ensured children and young people were treated in an age-appropriate way. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in

Summary of findings

records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role.

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 used the local services Fit 4 Work which supported people to get back into the work place after a period of sickness absence. In addition the practice staff had received training to promote and encourage self care by patients. The practice offered open access appointments each morning. Working age patients told us this was useful. 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.

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 patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability, offered longer appointments and or home visits for people with a learning disability. The practice worked with multi-disciplinary teams to support vulnerable people and this included asylum seekers. Staff knew how to recognise signs of abuse in vulnerable adults and 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice told us they needed to work within the confines of the local mental health service and found there were long waiting times for patients to be assessed by community mental health services. Patients with alcohol dependency had the option to self-refer to the community support

team and an in house drop in weekly service was available for patients with drug dependency. The practice was currently reviewing patients to identify those with dementia and referring them to a memory clinic for assessment.	

Summary of findings

What people who use the service say

During our visit, we spoke with two patients. They told us that the GPs and nurses working at the practice were very good. They told us that the GPs, the care they received and access to appointments were good. We also spoke with three members of the practice's patient participation group (PPG). They told us that the practice was trying to establish more interest and participation from the practice patient list. All three members of the PPG told us that the service they received from the practice was very good and they thought the open access surgery each morning was excellent.

We received 14 completed CQC comment cards; all but one were positive about the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

The practice had analysed the results of the returned Friends and Family Test questionnaires for February and March 2015 and displayed the results and the practice response to issues in the patient waiting rooms. The results were displayed in an easy to read pictorial format. The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience of the GP service they receive.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). For example, 90% of respondents described their experience of making an appointment as good (CCG 70%); 91% of respondents said they found it easy to get through on the phone (CCG 75%) and 92% stated they were satisfied with the surgery opening hours (CCG 76%).

Areas for improvement

Action the service SHOULD take to improve

- Ensure a formalised plan of action to monitor, review and reduce the rate of prescribing hypnotics if appropriate is recorded and implemented.
- Ensure a standardised approach to recording written consent from patients before any minor surgery procedure is undertaken.

Outstanding practice

We saw some examples of outstanding practice:

- The practice was committed and supportive to improving palliative care services to its patients and was working very closely with the palliative care teams to make sure patients received appropriate end of life care.
- The practice actively screened patient blood test results to identify those that were pre-diabetic. Those identified were invited in to an appointment to discuss the risk of developing diabetes and review lifestyle choices to mitigate this risk.
- The practice initiated insulin therapy on-site, instead of having to attend the local hospital.
- The practice was supporting patients with 'Self Care' which is an initiative to build confidence and knowledge for patients to manage their own minor ailments and so reduce the frequency of appointments with a GP.

Whitley Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and another CQC inspector. The team included a GP and a specialist advisor who has experience of practice management.

Background to Whitley Road Medical Centre

Whitley Road Medical Centre is located in Collyhurst, Manchester and is part of the NHS North Manchester Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. There are 6615 registered patients.

There are high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male life expectancy in the practice geographical area is 74 years compared with England average of 79 years and female life expectancy is 79 years compared with the England average of 83 years.

The practice opens from 8.30 am to 6 pm Monday to Fridays. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Go To Doc.

The practice has four GP partners (three male and one female) and two female salaried GPs. There are two female practice nurses, one health care assistant, a practice manager, an office manager, and reception and administration staff. The practice is a GP training practice.

On line services include appointment booking and ordering repeat prescriptions.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. 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 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service 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 (QOF) 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?

Detailed findings

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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We carried out an announced visit on 3 June 2015.

We spoke with a range of staff including four GPs, two practice nurses, a health care assistant (in training), the phlebotomist /data entry clerk, a secretary, reception staff, administration staff, and the practice manager. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information. In addition we spoke with two health care professionals who worked with the practice to improve and deliver palliative care services.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Interviews with staff confirmed that incidents were appropriately reported and where improvements and actions were required these were responded to appropriately. Staff told us that they felt confident to report adverse events and incidents.

Minutes of meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had been part of a Clinical Commissioning Group (CCG) pilot to report significant events, incidents and accidents to the CCG using a specific data collection computer programme. Feedback from the CCG and the practice was that the new reporting system was better than previous reporting method. More incidents, complaints and events were included in the newer data collection tool, which in turn enabled improved recording and monitoring, which was used to identify improvements and help learning.

We reviewed records of significant events that had occurred during the previous 12 months. Significant events were reviewed and discussed at the practice's monthly clinical meeting and where appropriate at reception team meetings. In addition, six monthly meeting were undertaken to review all significant events from the previous six months.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Staff when interviewed told us about significant events, the outcome of investigations and resulting changes made to minimise future reoccurrence.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff confirmed they received these by email. We saw clinical audits had been carried out in response to these safety alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records that showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One staff member provided us with an example where they had referred a patients to the children's safeguarding team. We were also provided with examples where staff had shared concerns with health visitors and of an incident identified by reception staff that was reported to the GP who took appropriate action. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had one GP as the lead for safeguarding vulnerable adults and children. The GP partners had received training to level 3 as required to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. In addition, two of the GP partners had had domestic violence training and there was awareness and monitoring for child sexual exploitation and female genital mutilation.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Monitoring of patients identified on the 'at risk' register and their attendance at emergency departments was also monitored.

There was a chaperone policy, which was visible in the patient waiting room. A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, the health care assistant and reception staff were trained to undertake chaperoning duties.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other medicines requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. Examples were also provided where the procedure had been used when a breach in the cold chain was identified. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date, including those kept in doctor's bags.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. The practice worked closely with the Clinical Commission Group (CCG) medicine optimisation team to review prescribing practices in line with best practice and national guidance. Data available indicated that the practice had high prescribing rates of some medicines such as hypnotics used in the treatment of sleeping/anxiety disorders. Although the practice was addressing this, no formalised written plan was in place.

The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist or chemist. This reduced the need to use paper prescriptions. Blank prescription forms were monitored and stored securely.

Medicines for use in medical emergencies were securely stored and staff knew where these were. One practice nurse had lead responsibility for checking stocks of medicines and their expiry dates. We saw these regular checks were recorded. Oxygen was kept by the practice for use in an emergency and was checked regularly. The practice had reviewed its need to have a defibrillator available and following this had decided they did not need one because 999 first responders and access to emergency departments were close by.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Regular cleaning audits were also undertaken. Comments recorded by patients on CQC comment cards referred to the practice as being clean and comfortable.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were changed in accordance with a planned schedule. Nursing staff told us about the cleaning they undertook between patient appointments to reduce the risk of cross infection.

The practice lead told us of the actions undertaken to monitor and improve infection control practices at the practice. These included using the knowledge, skills and tools provided by the infection control lead from the local authority. Infection control audits from 2013 and re-audits for 2014 were available and these showed there was significant improvement in the practice's implementation of infection control. Staff we spoke with confirmed regular checks were undertaken and demonstrated a good understanding of their role in promoting good infection control practices.

Good

Are services safe?

Procedures for the safe storage and disposal of needles and waste products were available. Staff had access to spillage kits and policies for needle stick injury and the management of specimens.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Evidence was available detailing the regular actions taken by practice to reduce any potential risk from this.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). PAT testing of electrical equipment had been undertaken, however annual calibration of some medical equipment was past their due date. We saw evidence that the original appointment for this to be carried out was cancelled and the practice had had to reschedule this.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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. All new employees working in the building were given induction information for the building, which covered health and safety and fire safety.

There was a staff handbook available for all staff and this was supported by a health and safety, general workplace and clinical policies and procedures for staff follow.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available.

Arrangements to deal with emergencies and major incidents

Staff described how they would alert others to emergencies by use of the panic button on the computer system.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment. Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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.

Good

Are services safe?

Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

The local community where Whitley Road Medical Centre had been classified as having high levels of multiple deprivation. (Multiple deprivation is when different types of deprivation e.g. lack of education, poor health, high crime levels, high unemployment are combined into one overall measure of deprivation, and are indicators of the quality of life that the local population experience). We found clinicians and staff were familiar with the needs of their local population and the impact of the socio-economic environment on their health and wellbeing. National data showed that the practice had 46.1% of patients in paid work or full time education compared with the England average of 61%. The practice also had 68.3% of patients with a long standing health condition compared with the England average of 54%.

The GPs and practice nurses had completed accredited training for checking patient's physical health and the management of various specific diseases. The GP partners told us they shared the clinical and corporate governance between them and all GPs supported the practice nurses to deliver their responsibilities in specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma.

Clinical staff told us the practice was focused on learning and developing to improve outcomes for patients. Monthly clinical meeting were held and minutes recorded showed that the clinical needs of patients and the services provided by the practice were reviewed. Nursing staff said that GPs were accessible when they needed advice or support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long term health conditions. We heard that updated guidance and research in relation to managing diabetes and the associated health care needs was reviewed and implemented following regular review. For example, one of the practice nurses supported Type 2 diabetic patients to start on insulin treatment. Traditionally injectable treatment for Type 2 diabetes was managed by specialist diabetes services. The practice nurse was knowledgeable about the food preferences of different cultures and religions and was able to assist patients to identify the most appropriate foods from their normal diet that would assist them to better manage their diabetes.

In addition, the practice nurse had implemented a protocol and strategy of identifying those patients who were at risk of developing diabetes. Those identified were invited to an appointment with the practice nurse to discuss the risks, review lifestyle habits and agree strategies to reduce the risk of going on to develop diabetes.

The practice had read coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP. The practice allocated a receptionist to a GP for six months periods of time. This had promoted strong working relationships between GP and the nominated receptionist and increased effectiveness. In addition, a buddying system was in place so that there was clarity of role and responsibilities when covering for absent colleagues.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice (89.9%) performed in line with the local clinical commissioning group in 2013/14 (89.8%), which was slightly below the England average of 94%. Data available to us showed that the practice achieved 806.6 points out of 897 for year ending March 2014. The practice told us that their performance had improved for the year ending March 2015.

QOF data indicated that the practice was below target for cervical screening. The practice was aware of this and used the standard recall system of sending out letters to remind patients they needed to make an appointment to have this

Outstanding ☆

Are services effective?

(for example, treatment is effective)

test. When this failed, the practice nurse tried ringing the patient to encourage them to come into the surgery. The practice nurse confirmed that they struggled to get patients to attend. The practice had recently worked with Nottingham University and volunteered to pilot an alternative method of promoting this screening. The practice confirmed the pilot methodology had not increased attendance for this screening.

GPs and a practice nurse told us about the clinical audits undertaken. We found that not all clinical audits completed two full audit cycles. One completed clinical audit we viewed showed appropriate changes in GP prescribing practices of Nitrofurantoin to those patients with poor kidney function. The practice nurse told us about the audit they had carried out to monitor patient's prescribed a diabetic medicine. Clinical team minutes showed that outcomes from clinical audits were shared and discussed.

The practice worked with other GP practices within the CCG and participated in monthly integrated care multidisciplinary teams meetings to discuss the care and support needs of patients and their families in the local neighbourhood. In addition, the practice attended monthly Gold Standard Framework (GSF) multidisciplinary meetings. GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life. Minutes from these meetings were available. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that these were comprehensive. All staff had access to a staff handbook which included a range of employment policies and procedures and included information on safeguarding and whistleblowing. Staff were up to date with attending mandatory courses such as annual basic life support. A training plan was in place for future training. We noted a good skill mix among the doctors

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had their revalidation date scheduled. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

The two practice nurses had defined duties and were leads for specific long term conditions. They were able to demonstrate that they were trained to fulfil these duties. One staff member was being trained as a health care assistant had had on the job mentoring from one practice nurse and attended an external training venue to support their education.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The practice was a training practice. We were told that two trainee doctor had just completed their placements.

The feedback from staff we spoke with was overwhelmingly positive. Staff were enthusiastic about working at Whitley Road Medical Centre. They told us that the patient was central to the services they provided and were clear how their contributions contributed and impacted on the whole being provided. They said they felt supported and trained to provide a good standard of service to patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 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. All staff we spoke with understood their roles and felt the system in place worked well. Significant event analysis provided evidence that the practice changed their procedures when gaps in performance were identified.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register, hospital admissions and discharges and attendance at A&E. These meetings were attended by other GP practices and a range of health care professionals such as district nurses and social services to improve end of life care for patients living in the community.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

In addition, the practice was working closely with the local hospital trust's Cancer and Palliative Care Improvement team and the Macmillan Cancer Improvement Programme Partnership to improve the quality of care and treatment to patients with cancer and or nearing end of life. Feedback from palliative care professionals confirmed that the practice worked closely with them and other GP practices to identify and risk assess patients on the cancer and palliative care registers to make sure the right care and support was in place at the right time for patients and that all the relevant healthcare professionals were aware of the patient's needs.

There was well established working relationships with other health care professional such as the diabetic nurse specialists and the Acute Respiratory Assessment Service at the local NHS hospital.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the staff teams, which confirmed good working relationships between them and good review and joint decision making in patient care.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

Consent to care and treatment

All clinical staff (GPs and nurses) we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. Staff we spoke with were also aware of Deprivation of Liberty Safeguards (DoLS) although they had not had training specifically in relation to this. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All 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).

The practice on occasion carried out some minor surgical procedures. For these minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. GPs we spoke with confirmed that they did not obtain a separate written consent to minor surgical procedures. To reflect good practice a standardised approach of recording written consent from patients, before any minor surgery procedure should be implemented.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, obesity management and travel advice.

The practice nurses held a variety of clinics including a twice weekly baby clinic and for specific problems and general health checks. The practice offered mixed clinics and specific health clinics such as diabetic clinic and chronic obstructive pulmonary disease (COPD) clinic for patients with respiratory disease. There was a lifestyle management support for example with smoking cessation. The practice also operated NHS health checks for patients between 40-74 years of age.

The practice staff had recently attended training to develop their skills to promote and encourage patient self-care. The aim of self-care was to empower patients with the confidence and information to look after themselves, and visit the GP only when they needed to. The practice was trying to support patients who attended the practice frequently with minor ailments. One practice nurse provided us with an example of the support they had provided to a patient. This resulted in a reduction in visits to the practice by the patient.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan

Outstanding ☆

Are services effective?

(for example, treatment is effective)

and manage services. The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). 90% of respondents described their experience of making an appointment as good (CCG 70%); 91% of respondents said they found it easy to get through on the phone (CCG 75%) and 92% stated they were satisfied with the surgery opening hours (CCG 76%). In addition, the patient survey results rated the practice consistently higher that the CCG and England average for all GP and nurse to patient contact, such as giving the patient enough time, listening, explaining tests and results and involving the patient in decisions about their care.

The two patients and three members of the patient participation group (PPG) all told us that the GPs and nurses working at the practice were very good. They told us that the GPs, the care they received and access to appointments were good. Patients particularly liked the open access surgery available each morning. 13 out of the 14 completed CQC comment cards we received contained positive comments.

The practice had analysed the results of the returned Friends and Family Test questionnaires for February and March 2015 and displayed the results and the practice response to issues in the patient waiting rooms. The results were displayed in an easy to read pictorial format. The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience of the GP service they receive.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area to avoid being overheard.

Consultations took place in rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 88.6% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 94.3% said they had confidence and trust in the last GP they saw or spoke to and 92.6% said the last GP they saw or spoke to was good at listening to them.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

GPs confirmed that all patients over 75 years had a named GP and basic care plans were in place for some vulnerable patient groups. Feedback from palliative care professionals confirmed that the practice was almost at their target of 1% of their patient population receiving a risk assessment and coding of their health and end of life care needs. The practice told us of the work undertaken with patients to make sure Statements of Intent were in place. A Statement of Intent provides information to Out of Hours GPs or other health care professionals who may be called to the patient's home, when the GP practice is closed.

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

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations. Detailed information was also available on the practice's website and practice leaflet. Their website also contained a section for 'Family Health', 'Long term Conditions' and 'Minor illnesses'.

The practice told us that they contacted family members after they had been bereavement and they were offered an appointment to come into the practice to discuss.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had identified that patients had to wait for a number of months following referral to secondary mental health services space out and were in discussion with the Clinical Commissioning Group (CCG) to identify how this could be improved.

The practice used the government sponsored initiative Fit for Work. Fit for Work is a support service to help employees stay in or return to work. The practice told us of some of the successes that their patients had at returning to work with the aid of support from Fit for Work. In addition, the practice recognised that some patients attended the practice more frequently with minor ailments. To support these patients' staff had attended two training sessions on Self Care to enable them to work with patients to raise their knowledge and confidence to self-care.

The practice was trying to establish an active Patient Participation Group (PPG) but were struggling to gain patient participation. We spoke with three member of the group who confirmed that at the first PPG meeting they discussed ways of trying to get patients interested in the group.

Tackling inequity and promoting equality

The practice building was an older building. All treatment and consultation rooms were on the ground floor. The building provided disabled access into the reception and waiting areas. Disabled toileting facilities were available.

The practice displayed its Mission Statement and Values and their patient charter in the patient waiting areas. Information with these documents stated that patients would be treated as individuals and their dignity respected.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. Staff we spoke with provided examples of where they provided tailored information to patients to support their cultural and religious needs.

Staff told us they had access to language line, but provided examples where they ensured an interpreter was available for patients at their appointments.

Staff spoken with were aware of the patients on their register who were also asylum seekers

Access to the service

The practice was open Monday to Friday 8.30 am until 6.00 pm. They closed for lunch 1 pm until 2 pm but information was available for patients about who to contact in an emergency during this time. The practice website and practice information booklet also contained details about who to contact for advice and appointments out of normal working hours and the contact details for the out of hours medical provider. The practice offered an open access surgery each morning and any patient arriving to see a GP before 10.30 am was guaranteed to be seen that morning. In addition six pre bookable appointments were available each day between 8.30 am and 9.30 am. The GPs also have offered telephone consultations and home visits. The practice nurses carried out some telephone triage of patients in the afternoon.

Appointments with the practice nurses were tailored to meet the needs of patients, for example, those with long term conditions and those with learning disabilities were given longer appointments. The practice nurses also undertook home visits to older patients and those vulnerable housebound patients.

Patients we spoke with, comment cards and patient survey results told us patients were satisfied with the service they

Good

Are services responsive to people's needs?

(for example, to feedback?)

received from the practice. Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 94.9% of respondents who described their overall experience of this surgery as good (CCG average 83.2% and England average 67.9%) and 95.3% said the last appointment they got was convenient (CCG 90% and England average 91/8%)

Listening and learning from concerns and complaints

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

Between 2014 and 2015 the practice had piloted (for the CCG) the use of a new recording tool /database to record all significant events and complaints. This meant a comprehensive spreadsheet was available detailing significant events and complaints and the action taken by the practice in response to these. In addition, practice had carried out biannual reviews of complaints in September and January 2015. We saw the practice responded to complaints proactively investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice. A number of examples were available which demonstrated the commitment of the practice to improve and develop its service. Learning points from complaints were discussed at staff meetings and incorporated into clinical supervision where relevant.

The practice told us they worked with the Macmillan Cancer Improvement Programme Partnership and had commenced reviewing patient's deaths in more detail to identify those which provided opportunities for the practice to learn from.

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 displayed its Mission statement, values and patient charter in the patient waiting areas. Its mission statement stated the aims of the practice was, "…..to provide the highest possible health care to our patients". A number of values including, "Make the care of our patient our first concern", supported this.

The staff we spoke with understood the practice vision and values. They told us that the vision and values of the practice was to put the patient at the centre of everything they did. All staff we spoke with demonstrated a commitment and enthusiasm and were engaged in providing a high quality service. Each member of staff had a clear role within the structure of the practice and there was recognition of staff members' contribution. The GPs we spoke with confirmed they worked together to develop both short term and longer term practice development plans and these were shared with all staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy if required. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed in line with the local clinical commissioning group in 2013/14. The practice told us they had improved there QOF points for year ending March 2015. The practice also monitored other data sources to benchmark performance and where issues were identified initiated action to improve.

Clinical audits were undertaken regularly by staff, although completion of two full audits was not always evident. Minutes of clinical meetings provided clear evidence that the outcome of the audits were discussed at team meetings and training and development days. A 12 month schedule of internal practice and external multidisciplinary team meetings was in place.

The practice had reviewed its administrative support arrangements for GPs and used a dedicated reception staff member for each GP. This had improved efficiency. Buddying arrangements when staff were absent were also in place. The practice had arrangements in place for identifying and managing risks. Risk assessments and risk management plans were in place.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership which articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice held a number of meetings at regular intervals that were documented. These included clinical, partner, administrative meetings as well as integrated care and palliative care multidisciplinary team meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

Are services well-led?

Good

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

Complaints were well managed. The practice investigated and responded to them in a timely manner, and records indicated that complainants were satisfied with the outcomes. These were discussed at staff meetings and were used to ensure staff learned from the issues raised.

There was a small active Patient Participation Group (PPG) which was trying to become more established. The representatives we spoke with anticipated a positive working relationship with the practice.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events

Management lead through learning and improvement

The practice worked well together as a team and held meetings for learning and to share information. The practice worked closely with the Clinical Commissioning Group to develop and improve services both for the practices and the wider locality. The practice worked with other GP practices and local health care teams such as the palliative care and MacMillan Cancer Improvement Programme.

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals, which included looking at their performance and development needs.

The practice had an induction programme for new staff and a programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities. Records of staff training and copies of training certificates were available.

Staff told us they had good access to training and support to undertake further development in relation to their role. The practice was a GP training practice and trainee doctors were supported by the GPs and other staff.

The practice recognised future challenges and areas for improvement, had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.