Newthorpe Medical Centre

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newthorpe Medical Practice on 16 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing an effective, caring, responsive and well led service. It was also good for providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health. It required improvement for providing safe services.

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

- Most risks to patients were assessed and well-managed, with the exception of those relating to recruitment checks.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, systems for recording, monitoring and addressing information about safety needed strengthening.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- We saw evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Most patients told us they generally found it easy to make an appointment with a GP or nurse and that there was continuity of care, with urgent appointments available the same day.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and most staff felt supported by management.

Summary of findings

- Arrangements were in place to review the training needs and professional development for staff to ensure it was appropriate to their roles.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff to ensure they are suitable to work with patients.

In addition the provider should:

- Ensure that care plans are personalised to patient's needs; and processes for recording mental capacity assessments are strengthened.
- Ensure all staff have access to appropriate policies, procedures and guidance to help them carry out their role including whistleblowing.
- Ensure safety and governance issues discussed at meetings are clearly documented to reflect required actions have been completed and reviewed.
- Ensure appropriate records are maintained so that the practice can be assured that training relevant to all staff has been completed.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Although most risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. This included recruitment of staff and pre-employment checks required by law.

The practice's systems needed strengthening to ensure that risk assessments and information about safety was recorded, communicated widely to practice staff, appropriately reviewed and addressed.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and shared widely to support improvement.

Suitable systems were in place in respect of infection control, medicine management, anticipating events, equipment checks, management of unforeseen circumstances and dealing with emergencies. Review arrangements were in place to ensure enough staff were present to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current best practice. This included assessing capacity and promoting good health; although the processes for recording mental capacity assessments needed to be strengthened.

Staff worked with multidisciplinary teams to promote coordinated care for patients; and systems for record keeping to reflect this work needed strengthening. We saw evidence that audit was driving improvement in performance to improve patient outcomes. Data showed most patient outcomes were in line and / or above for the locality.

Records reviewed showed some staff had not completed their mandatory training and received recent appraisals. However, the practice had identified that systems for monitoring staff training and appraisals required improvement and actions plans were in place to meet these needs.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

Data reviewed showed patients rated the practice higher than others for several aspects of their care. The January 2015 national patient survey results showed 92% of respondents said GP they saw or spoke to was good at treating them with care and concern.

The majority of patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

We found staff treated patients with kindness and respect, and maintained confidentiality. Care planning arrangements were in place to ensure patients received appropriate care and support; however some care plans were not always personalised.

Information to help patients understand the services available was easy to understand. The care needs of carers were identified and support was provided to address them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a statement of purpose in place to promote positive patient outcomes. Most staff felt supported by management and a clear leadership structure was in place. The practice had a number of policies and procedures to govern activity and held regular management / clinical meetings.

Summary of findings

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

Improvements were being made to strengthen the systems in place to ensure that staff received regular performance reviews as part of their professional development.

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.

Every patient over the age of 75 years had a named GP. The practice offered proactive care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and end of life care.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Flu and shingles vaccinations were offered to older patients in accordance with national guidance.

The practice was responsive to the needs of older people, and offered longer appointments and rapid access appointments for those with enhanced needs. Home visits to patients in their own homes or care homes were carried out when requested. Monthly multi-disciplinary care meetings were held to ensure integrated care for older people with complex health care needs.

People with long term conditions

Good

The practice is rated is good for the care of people with long term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. We saw good examples of joint working with community nurses specialising in diabetes management and chronic obstructive pulmonary disease (COPD) for example. Longer appointments and home visits were available when needed.

The practice maintained registers of patients with long term conditions. Patients were offered a structured annual review to check that their health and medication needs were being met.

Recall systems were in place to ensure patients attended. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people

Summary of findings

There were systems in place to identify and follow up vulnerable adults and children living in disadvantaged circumstances and who were at risk of abuse. The monitoring of children and young people who had a high number of A&E attendances needed strengthening.

The practice offered a full range of childhood immunisations as well as ante-natal and post natal monitoring of both mother and baby. We saw good examples of joint working with midwives and health visitors.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected 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 people with a learning disability. It had carried out annual health checks for people with a learning disability and longer appointments where needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients could access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

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).

People experiencing poor mental health and dementia were offered an annual physical health check and a review of their care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. This included regular liaison with the community psychiatrist nurse who visited the practice weekly.

The practice carried out advance care planning for patients with dementia and recording of mental capacity assessments needed strengthening.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. There was a system in place to follow up patients where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection including two members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. Patients told us they were satisfied with the care they received. They all told us that staff were helpful, caring and professional. They also said staff treated them with dignity and respect.

We reviewed 54 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. The majority of comments were positive although 13 comment cards had less positive feedback.

Common themes were: that patients were treated with dignity and respect; the practice was clean and tidy and staff were caring, very helpful and reassuring. The less positive themes were in respect of availability of non-routine appointments, the prescription service and continuity of care.

Patients praised the care and treatment they received. They felt staff listened to them, were accommodating and involved them in decision making. They described their experience of making an appointment as good, with urgent appointments available the same day. They also said children were treated in an age appropriate manner and offered same day appointments.

Less positive feedback mainly related to the appointment system, waiting times and phone access. We looked at the national patient survey published in January 2015. The results showed the practice performed above the local average for satisfaction scores in respect of consultations with GPs and nurses, appointments and phone access.

For example: 88% of respondents would recommend this surgery to someone new to the area and 90% described their experience of making an appointment as good. This was above the local CCG average of 75%. Ninety two percent of respondents said the last GP they saw or spoke to was good at treating them with care and concern and 91% said the last nurse they saw or spoke to was good at involving them in decisions about their care.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff to ensure they are suitable to work with patients.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure that care plans are personalised to patient's needs; and processes for recording mental capacity assessments are strengthened.
- Ensure all staff have access to appropriate policies, procedures and guidance to help them carry out their role including whistleblowing.
- Ensure safety and governance issues discussed at meetings are clearly documented to reflect required actions have been completed and reviewed.
- Ensure appropriate records are maintained so that the practice can be assured that training relevant to all staff has been completed.

Newthorpe Medical Centre

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 specialist advisor and a practice manager specialist advisor.

Background to Newthorpe Medical Centre

The Newthorpe Medical Centre provides primary medical services to approximately 6640 patients living in the Eastwood, Newthorpe, Giltbrook, Nuthall, Watnall, Kimberley, Awsworth and Cossall areas.

The practice holds a Personal Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community over and above the General Medical Services (GMS) contract. The practice provides a range of services including: child health clinics, family planning advice, antenatal and postnatal care, vaccinations and health checks for patients with long term conditions.

Newthorpe Medical Practice employs a total of 22 staff members. The clinical staff include four GP partners and one salaried GP. Three of the GPs are male and two are female. The practice is also a training practice with two GP trainees and one second year foundation GP. They are supported by a practice manager, administration manager, 13 administrative staff and two cleaners.

Newthorpe Medical Practice has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out-of-hours service is provided by Nottingham Emergency Medical Services (NEMS).

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme

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

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England local area team. We carried out an announced visit on 16 January 2015. During our visit we spoke with a range of staff (GPs, practice nurses, practice manager, reception and administrative staff).

We spoke with five patients who used the service and observed how people were being cared for. We reviewed 54 patient comment cards sharing their views and experiences of the practice. We also spoke with three other health and social care professionals.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts, as well as 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.

We found national patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with confirmed the alerts were emailed to them and were accessible from the practice's shared drive. They also told us it was their individual responsibility to review the information.

Some clinicians we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. This included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), responsible for the regulation of medical devices.

However, the system in place was not robust in that it did not ensure that all relevant staff who needed to know about the alerts had seen them; and there was no system for checking that appropriate action had been taken where needed and shared with relevant staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. This included the use of significant event forms by staff to report concerns. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every three months to review the events. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We reviewed the records of significant events that had occurred during the last two years. This included events linked to missed blood results, new cancer diagnosis, complaints, compliments and deaths where terminal care had taken place at home. The records showed evidence of discussion amongst staff which ensured shared learning and contribution to determining any improvement action that might be required.

We saw that recommendations for future actions were noted in the meeting minutes. However, there was an inconsistent system of recording the person responsible for actions and there were instances where there was no evidence recorded to confirm that identified actions had been completed.

In one example, we saw that a new system was trialled to reduce the waiting time for referral letters being sent out in response to a complaint raised about a delayed referral for Parkinson's disease screening. We found suitable systems were in place to audit referrals made.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. The available training records we looked at showed some staff had received relevant role specific training on safeguarding, and additional training for staff had been booked.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and staff could access safeguarding information from a designated folder.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level and could demonstrate they had the necessary training and understanding to enable them to fulfil this role. Most of the staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system in place 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. Two GPs we spoke with showed us records to confirm they were appropriately using the required codes on their electronic case

management system. This ensured risks to vulnerable adults, children and young people who were at risk of abuse, looked after or on child protection plans were clearly flagged and reviewed.

The lead GPs we spoke with demonstrated awareness of the practice's policy, safeguarding referral procedures and the multi-agency safeguarding hub. One GP told us where safeguarding concerns had been raised by A&E and out of hours services, arrangements were in place to ensure the patient's needs were reviewed by a GP in a timely manner.

There was no formal system in place for identifying children and young people with a high number of A&E attendances; this was dependant on individual GP's noticing this on the patient record. However, monthly meetings were held with the health visitor and school nurse to review children with concerns and agree follow-up action where required. This included follow up of children who persistently failed to attend appointments for childhood immunisations. Some records we reviewed demonstrated good liaison with partner agencies.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants had been trained to be a chaperone.

Reception staff would act as a chaperone if nursing staff were not available and certificates seen showed they had undertaken relevant training. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Patient records were coded or a free text was noted in the medical records of patients where a chaperone had been present.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring 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.

For example, we saw that the practice had responded appropriately to a significant event where fridge temperatures had not been low enough for 72 hours due to a power failure. The vaccines were discussed and other relevant agencies such as the respective drug companies, health protection agency and the local clinical commissioning group were informed.

Records reviewed showed checks on fridge temperatures were undertaken twice daily between Monday and Friday; and the data logger (monitors temperature in vaccine fridges) was reviewed weekly to ensure all temperatures were within the manufacturers recommended range of safe use.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, repeat prescriptions for disease-modifying anti-rheumatic drugs (DMARDS) were for a maximum of three months and a system was in place to check that patients had attended for regular blood tests. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had a repeat prescribing policy in place and patients could make their requests in person, handwritten or online.

There was a system in place for reviewing repeat medications for patients with co-morbidities and / or multiple medications. Review dates were recorded on the repeat prescription and if medicines were required past the review date they had to be re-authorised by a GP.

The practice had initiated the use of electronic prescribing. However, they had been experiencing difficulties with the

pharmacy receiving prescriptions despite evidence confirming the prescriptions had been sent. The practice was logging these incidents and liaising with the pharmacy to resolve the issues.

The practice held stocks of controlled drugs such as diamorphine. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. The practice had in place standard procedures that set out how they were managed and these were being followed by the practice staff.

For example, controlled drugs were stored in a secure location and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be visibly clean and tidy. The practice employed two cleaners. We saw there were cleaning schedules in place and cleaning records were kept. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We were told that all staff received induction training about infection control specific to their role and received annual updates. However, we could not confirm this as training records for all staff were not available.

The practice could not provide when requested information to demonstrate that all relevant staff had received appropriate Hepatitis B immunisations to minimise risk to themselves and patients. We saw evidence of an audit having being completed in December 2014 and most of the improvements identified for action were completed.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records reviewed showed a risk assessment had been completed in November 2013 and practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. There were arrangements in place for the safe disposal of clinical waste and sharps, their disposal was arranged through a suitable company.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, this was not always followed to ensure that appropriate checks had been undertaken before staff were employed.

For example, four staff files we looked at did not contain most of the required information to ensure staff were suitable to work with patients. This included proof of identification, qualifications, a full employment history, satisfactory evidence of conduct in previous employment, satisfactory evidence about any health related conditions and criminal record checks.

The practice acknowledged that records for all staff pre-employment checks needed to be reviewed to ensure they were up to date; or where needed to ensure an appropriate risk assessment was in place. This had not been addressed at the time of our inspection; therefore we could not be assured that robust recruitment and selection processes were in place.

Requires improvement

Are services safe?

We saw there was a rota system in place for different designations of staff to ensure that there was sufficient people working at the practice to keep patients safe. Records reviewed demonstrated that actual staffing levels and skill mix were mostly in line with planned staffing requirements.

Some of the administration and reception team we spoke with told us they were sometimes understaffed but this did not impact on patient care. They told us they worked as a team to ensure safe care was delivered and that staffing needs were being reviewed by the management. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and or sick leave; and this was being monitored by the practice.

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. These included annual checks of the building, the environment, medicines management and equipment.

We saw completed risk assessments in respect of young people, the car park, and cleaning equipment. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. However, there was no risk assessment for cleaning products and equipment subject to the control of substances hazardous to health Regulations (COSHH).

Some staff told us risk assessments were not always discussed with them and this included the health and safety policy. This did not ensure that all staff were aware of the identified health and safety representative and the action they needed to take to mitigate identified risks.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: if reception were concerned that a patient was acutely ill there was a system in place to alert the GP's. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice also monitored repeat prescribing for people receiving medication for mental ill-health. There were emergency processes in place for patients with long-term conditions and nurses we spoke with gave examples of referrals made for patients whose health deteriorated suddenly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records available showed most staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

All the medicines we checked were in date and fit for use. Medicines kept in doctors bags were recorded and their expiry dates monitored by the practice nurse. We noted that GPs carried penicillin in their bags but there was no alternative medicines carried should a patient be allergic to that particular antibiotic. We were told this was managed by contacting emergency services such as 999 or an ambulance.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been discussed at a practice meeting on 28 November 2014 and was due for review in July 2015.

Mitigating actions to reduce and manage the identified risks were recorded. Risks identified included: loss of access to the medical database and paper medical records, power failure, adverse weather, incapacity of staff and an epidemic. The document also contained relevant contact details for staff to refer to including local hospitals and utility companies. This included buddy arrangements with another GP practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had practised one fire drill and that some staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw that clinical staff could access relevant policies and NICE guidance from the practice shared drive. We found from our discussions with the GPs and nurses that staff completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

One of the GP partners took a proactive approach in developing and / or modifying templates within the patient electronic system. This supported clinical staff in their assessment and review of patient needs. For example, the clinicians used in-house templates for chronic disease management to ensure they were working within recommended treatment targets. This included blood pressure targets for specific long term conditions and the computer prompted the clinicians if further reviews were required.

The practice completed a review of case notes for patients with high blood pressure to ensure they all were receiving appropriate treatment and regular review. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice nurses led in specialist clinical areas such as asthma, diabetes, heart disease and high blood pressure; and were supported by the GPs where required. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported staff to continually review and discuss new best practice.

We saw limited records of practice meetings where new guidelines were disseminated, the implications for the practice's performance and required actions agreed

The practice was aware it had high prescribing costs and held meetings with the Clinical Commissioning Group (CCG) pharmacist lead to review the practice's performance for antibiotic prescribing. We saw examples of clinical audits in respect of medicines in response to the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and Nottingham prescribing committee guidance.

For example, an audit was undertaken following new guidance on the maximum daily dose for citalopram (commonly used in the treatment of depression). The audit identified 95% of patients had been prescribed citalopram in line with new guidance; and the GPs had carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice where needed.

All GPs we spoke with used national standards for the referral of patients. For example patients with suspected cancer were referred and seen within two weeks. We saw records where reviews of elective and urgent referrals were made and that improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. The practice showed us 12 clinical audits that had been undertaken in the last four years. Three of these were completed audits where the practice was able to demonstrate the changes to treatment or care resulting since the initial audit.

One of the GP partners had taken a lead in participating in the Royal College of General Practitioners (RCGP) national cancer audit following evidence that showed cancer was diagnosed later in the UK than other European countries. The practice audit critically looked at the last six months of their patients with a cancer diagnosis and reflected on general practice encounters prior to the diagnosis being made and where performance could be improved.

Good

Are services effective?

(for example, treatment is effective)

The outcome of the audit was discussed at a significant event meeting and there was evidence of a robust discussion to promote reflection and shared learning. This included how the practice could enhance patients' uptake of cancer screening programs and the practice's use of decision making tools.

For example, the practice offered prostate specific antigen (PSA) screening which identifies if a male patient has an increased risk of prostate cancer. Two comment cards we received stated quick referrals for breast cancer had been made and patients were successfully treated.

The GPs told us clinical audits were sometimes linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

One GP told us as a result of incorrect prescribing of hormone replacement therapy (HRT is a treatment used to relieve symptoms of the menopause) an audit on patients prescribed this medicine was undertaken. The audit identified this was a one off; and patients were receiving appropriate medicines and prescribing guidance was recorded on repeat prescriptions to prevent the error reoccurring.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes, asthma, chronic disease and heart failure. This practice was not an outlier for any QOF (or other national) clinical targets.

The 2013/14 QOF data showed 76.3% of patients on the asthma register had an asthma review in the preceding 12 months and 86.7% of patients diagnosed with dementia had received a face to-face review in the preceding 12 months. The practice took a team approach to the monitoring of its QOF data. Each clinician had their own defined QOF areas to monitor and account for.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting this was helped by being a training practice for trainee doctors.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

There was a protocol for repeat prescribing which was in line with national guidance. In line with 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 patients with 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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice worked towards the gold standards framework for end of life care and implemented principles of delivering personalised care to patients who were approaching the end of their life. Staff maintained a palliative care register and regular multidisciplinary meetings were held to discuss the care and support needs of patients and their families.

The practice had started to use the end of life template to enhance communication with community based staff and the out of hours service Nottingham Emergency Medical Services (NEMS). The template included information on diagnosis, the patient's preferred place of care and resuscitation decisions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice leadership acknowledged that the record keeping for staff induction, training, supervision and appraisal needed improvement to ensure effective systems were in place to monitor staff professional development.

Good

Are services effective?

(for example, treatment is effective)

We found the practice had initiated some improvements to address this. For example: the practice manager was in the process of developing a system to ensure that the overall training needs and refresher updates for all staff was monitored, and staff had been requested to submit their training certificates to inform the auditing of their training needs.

The practice had also developed a new induction template for future use and appraisals for some staff had been scheduled as these had not always been undertaken. We were given examples where poor performance in staff had been identified and the appropriate action taken to manage this.

Our interviews with staff confirmed they had received an induction and e-learning was completed during quiet times within their normal working hours. The practice facilitated protected learning time and staff told us it was optional and would request for it if needed. Records reviewed showed not all staff had completed mandatory training in line with practice policy. However, arrangements were in place to ensure all staff had completed their mandatory training and that appropriate records were kept by the management to reflect this.

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

As this was a training practice, doctors who were training to be qualified as GPs offered extended appointments for patients and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with. They told us they were well supported with their training and had regular supervision. This included debriefs after their practice session and observations of patient consultations as part of their supervision by their trainer. Locum GPs were provided with an information pack to orientate them to the practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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 and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). A process was in place for reception staff to send reminders if the duty GP had not reviewed information from A&E and out of hours service. We saw that the procedures for actioning hospital communications was working well in this respect.

We were told the CCG arranged for district nurses to contact patients within 48 hours after discharge as part of the admissions avoidance enhanced service. The practice was then responsible for developing care plans and reviewing admissions, and the needs of complex patients at monthly multi-disciplinary meetings.

These meetings were attended by district nurses and community matron for example; and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

One health professional who attends these meeting told us effective discussions and good case management of patients were facilitated, and this ensured better outcomes for patients. Professionals in secondary care for example hospitals, had access to the practice's priority telephone line and could make appointments for when patients were discharged.

The practice worked in partnership with other health and social care professionals to deliver effective and coordinated care for patients. For example, GPs liaised with the community geriatrician and community matron in

Good

Are services effective?

(for example, treatment is effective)

respect of care for older people and people with long term conditions. The community psychiatric nurse and psychiatrist used the practice for outpatient appointments and this allowed clinicians' to access their advice and support and / or share information on patient needs.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

We found choose and book referrals were completed within 48 hours and urgent referrals were made on the same day. Records reviewed showed a regular auditing system was in place and this included use of a log book to record all referrals before they were sent and urgent two week wait referrals were followed up by individual GPs. A referral protocol was in place and staff told us this was used as a reference in practice meeting; however this was last reviewed in 2007.

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. The practice had not specified an exact date when this would be achieved but had a statement of intent indicating that the issue was one of compatibility with the computer system and they expected this to be resolved in the near future. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice staff also used instant messaging for communication of tasks

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All but one of the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. In house training was provided for staff and meeting minutes reviewed showed the Mental Capacity Act 2005, had been discussed at the practice meeting held on 28 November 2014.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. 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.

Some records we looked at showed decisions about a patient's capacity were recorded in clinical notes. Most of the 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).

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

Health promotion and prevention

It was practice policy to offer a health and well person check to all new patients registering with the practice. The GP was informed of all health concerns detected and we were told these were followed up in a timely way.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the practice identified the smoking status of patients over the age of 16 and offered smoking cessation advice to smokers. 95.3% of patients with physical and/or mental health conditions had their smoking status recorded in the preceding 12 months.

The practice offered NHS health checks to all its patients aged 40 to 75 years and flu vaccinations to older people and people with longer term conditions. For example,

Good

Are services effective?

(for example, treatment is effective)

74.5% of patients aged 65 and older had received a seasonal flu vaccination. The practice offered a full range of immunisations for children and travel vaccines in line with current national guidance.

There was a policy for following up non-attenders and effective recall systems were in place to ensure the regular reviews of patients with long term conditions; for example hypertension, asthma and health screening checks.

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

The practice had undertaken an audit of cervical screening activities between 19 March 2013 and 28 January 2014. The audit showed adequate cervical cytology samples were collected. 87.9% of women aged between 25 and 65 years had a record of cervical screening having been performed in the preceding 5 years. This was above the national average of 81.9%.

There was a policy to offer telephone reminders for patients who did not attend for cervical screening and the practice audited patients who did not attend. There was also a named nurse responsible for following up patients who did not attend screening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey results, a survey of 203 patients undertaken by the practice and results from the family and friends test. The evidence from all these sources showed most patients were satisfied with the care they had received and were sufficiently involved in making decisions about their care.

The practice scored well for its satisfaction scores on consultations with doctors and nurses in the national patient survey. For example, 96% of practice respondents said the GP was good at listening to them and 94% said the GP gave them enough time. 98% also said the last nurse they saw or spoke to was good at treating them with care and concern; and 93% described their overall experience of this surgery as good.

The practice's 2014 survey results showed 100% of respondents were happy with the care they received and 98% felt the reception staff were polite, helpful, and treated them with respect and dignity.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 54 completed cards and the majority were positive about the service experienced. Patients felt the practice offered an excellent service and staff were professional, helpful and caring. They said staff treated them with dignity and respect. 13 comments were less positive and common themes were in respect of availability of appointments and waiting times.

We also spoke with five patients on the day of our inspection. All the patients told us they were satisfied with the care provided by the practice and that staff provided reassuring information and advice.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Reception staff told us that if a patient wished to speak with them confidentially, they would take them into a separate room.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

The practice provided care and treatment for patients whose circumstances may make them vulnerable. This included older people living in care homes and people with a learning disability or experiencing poor mental health. Staff told us these patients were able to access the practice without stigma and that home visits were provided when needed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

For example, the January 2015 national patient survey results showed 93% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining treatment and results. Both these results were above the local average for the CCG area which was 82% and 83% respectively.

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

Good

Are services caring?

Patient feedback on the comment cards we received was mostly positive and aligned with these views. Two parents stated their children were treated in an age-appropriate way, were recognised as individuals and had their preferences considered during consultations.

We were shown examples of completed care plans for people with long-term conditions, learning disability and older people. We saw evidence of patient involvement in agreeing these, details about carers and contact details for professionals involved in their care. However, we found these care plans were not always personalised and staff used a standard template to capture information. Where care plans had been personalised this related to impairments or specialist support required.

The practice had signed up to the enhanced service to help avoid unnecessary hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. Clinical staff told us that patients at high risk of being admitted to hospital, including elderly patients and people with complex needs or in vulnerable circumstances, had an anticipatory care plan in place to help avoid this.

The care plans included patient's wishes, decisions about resuscitation and where they wished to die. This information was available to the out-of-hour's service, ambulance staff and local hospitals. The practice used an alert system to ensure that the out-of-hours service were aware of the needs of these patients when the surgery was closed.

The practice staff knew their patient group well and compliments in respect of their caring and helpful nature were received. Staff gave examples of how they supported patients when needed. For example helping elderly patients ring for a taxi and informing patients of their appointment if they had difficulty in using the call system.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 92% of respondents to the national patient survey said the GP they saw or spoke to was good at treating them with care and concern and 100% had confidence and trust in the last GP they saw or spoke to.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. The cards highlighted that staff responded compassionately when they needed help and provided support when required. Some of the patients told us they received help to access support services to help them manage their treatment and care when it had been needed.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. These included community services for mediation, day centre activities, a mental health drop in self-help centre, support with eating disorders and carers federation.

The practice's computer system alerted GPs if a patient was a carer. The practice had been involved in developing carers health assessments in recognition that carers often neglect their own health needs therefore needed support to ensure their wellbeing was monitored. The practice promoted health screening checks such as cervical smears and mammograms for carers.

A member of the Carers Federation attended the surgery regularly to offer information and support for carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families that had experienced bereavement could contact the practice for support. This included a patient consultation at a flexible time and location to meet the family's needs, or giving them advice on how to find a support service.

The practice assessed people with long-term conditions and multiple health needs for anxiety and depression, and recognised isolation as a risk factor for older people. Where appropriate information and advice was given to patients to address this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We saw evidence of partnership working to understand the needs of the most vulnerable in the practice population. Regular multidisciplinary meetings were held to discuss patients with complex needs or at risk, including people with poor mental health, learning disabilities or receiving end of life care. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

We also spoke with representatives from two local care homes. They told us patients were promptly seen where required and their needs were regularly reviewed. They were satisfied with the service provided by the practice.

We found the practice provided a wide range of services to meet patients' needs, and enable them to be treated locally. For example, child health clinics are held every week on a Tuesday morning by appointment.

Antenatal and postnatal care, vaccinations and regular reviews for patients with chronic conditions were also provided. The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other local services.

The practice website contained detailed information patients could refer to. This included information and videos on healthy living, common ailments that can be self-managed and chronic conditions.

We saw that systems were in place to ensure that test results, information from the out-of-hours provider and letters from the local hospital including discharge summaries were promptly seen, correctly coded and followed up by a GP, where required. Systems were also in place to ensure that patients were promptly referred to other services, where required.

The practice worked in partnership with the patient participation group (PPG) and responded to information to meet patients' needs. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients and the PPG. For example, as a result of patients requesting more appointments, the surgery will open on a Thursday afternoon from 01 February 2015.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example services for people with a disability and people whose first language was not English.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was situated on the first and second floors of the building with patient services on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A hearing loop facility was available and an outside ramp; although one wheelchair user commented they had difficulties navigating the ramp.

Staff told us that translation services were available for patients who did not have English as a first language. The majority of the practice population spoke English therefore translation services were not regularly used. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed or had access to the equality and diversity training; and that equality and diversity was regularly discussed at team events.

The practice maintained a register of people who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records. Meeting minutes reviewed showed discussions were held in respect of using a gentle and sensitive approach when supporting vulnerable patients, including people with mental health needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. Staff told us all patients received the same quality of service to ensure their care needs were met.

The practice's 2014 survey results showed newly registered patients were generally very satisfied with the registration process and people were easily able to register with the practice. All respondents found staff were helpful when enquiring about registration and the patient information pack satisfactory.

Access to the service

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's 2014 survey covered areas such as phone access, appointment waiting time and being able to see a GP of choice. The survey results showed positive feedback with most respondents rating the practice between good and excellent. These results were aligned with the January 2015 national patient survey results which showed the practice performed well above the local CCG average in respect of phone access and the appointment system.

For example: 90% of respondents found it easy to get through to this surgery by phone (above CCG average of 74%); 90% described their experience of making an appointment as good (above CCG average of 75%); 91% of respondents said the last appointment they got was convenient (local CCG average 92%) and 85% of respondents usually wait 15 minutes or less after their appointment time to be seen (local CCG average: 65%).

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had a range of appointments to suit different population groups. For example, longer appointments and home visits were available for patients who needed them including older people and people with long-term conditions. This also included appointments with a named GP or nurse.

Appointments were available outside of school hours for children and young people and the practice had suitable premises for children and young people. The needs of the working age people were understood and services reflected this. For example access to an online booking system, telephone consultations where appropriate and support to enable people to return to work.

The practice was opened from 8am until 6:30pm each weekday except Thursday when the practice closed at 12.30pm. The practice had plans in place to open all day on Thursday from February 2015. Extended opening hours were offered on Monday and Friday from 07:10am to 8am and this was particularly useful to patients with work commitments. 89% of respondents to the national patient's survey stated they were satisfied with the surgery's opening hours.

The mental health needs of the practice population were monitored and informed service provision. This included flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including posters displayed on noticeboards. Patients we spoke with were aware of the process to follow if they wished to make a

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at nine complaints received in the last 12 months and found these were satisfactorily handled.

Staff told us there was an open and transparent culture for dealing with complaints. This included discussing complaints as significant events with all staff to promote shared learning and where appropriate an apology letter was sent to the patient. The practice may wish to review complaints annually to detect themes or trends.

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's statement of purpose included some of the following values: respect and involve people who use our services, empower and communicate with our patient community, and improve the health of our patients. Staff we spoke with could identify with the values and explained how their individual roles met these goals.

The leadership team told us they were committed to being a well led practice and were working towards improving areas they had identified as challenges. We found they had sought peer support from the Local Medical Committee and the locality group of GP practices as needed.

Staff told us of changes which had happened within the practice management in the last three years and how they had coped as a team to manage the changes. Some staff confirmed they were not always fully involved in discussions about the vision and succession planning therefore were not fully aware of their responsibilities in relation to these.

The leadership told us they were working towards developing a clear vision and objectives given the new leadership; and this would be 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 as paper copies and / or from the practice shared drive. Most staff we spoke with knew where to find these policies if required and would ask the practice manager if in doubt. Most of the policies and procedures we looked at had been reviewed and were up to date. The practice manager was responsible for human resource policies and procedures.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding children. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Most of them told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had achieved a total of 97.7% QOF points in 2013/14 with most areas achieving the maximum points. For example, care for chronic kidney disease, depression, learning disability and epilepsy.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Completed audits were in respect of: knowledge and pregnancy advice for women with diabetes; management of cholesterol in patients with chronic heart disease; anti-coagulation and atrial fibrillation. The standards for audit were clearly documented including changes in practice.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments which addressed a wide range of potential issues for example fire and car parking. We saw that the risk assessments had been updated in a timely way. We were told regular clinical and governance meetings were held to discuss performance, quality and risks.

Leadership, openness and transparency

Staff we spoke with felt the team was very supportive of each another and that management were approachable. The clinical staff held regular meetings to discuss and improve clinical outcomes for patients.

The practice had a whistleblowing policy which was available to all staff but not all staff we spoke with knew its content. Staff told us they had no cause to use it as an open culture was promoted within the practice, and were happy to raise issues at team meetings.

The practice manager told us she was open to staff ideas for improvement but we found no examples of changes made to service provision as a result of staff feedback.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Are services well-led?

Good

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

The overall aim of the group "is to develop a positive and constructive relationship between patients, the practice and the community it serves, ensuring the practice remains accountable and responsive to all its patient's needs". The PPG comprised of 19 members and engaged via face to face meetings, email, website and notice board notices.

The practice had gathered patient feedback through patient surveys, suggestion box, family and friends comment cards and complaints. The practice manager showed us the analysis of the 2014 patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

We looked at the results of the 2014 patient survey and saw that all respondents were happy with the care received. We saw as a result of patient feedback the practice had agreed to the following: a new notice board had been placed in prominent position to post PPG meeting dates, advertise for new members and post results of feedback; a newsletter had been introduced and new measures were implemented to reduce waiting times and increase appointment availability.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. However, the staff files we looked showed that regular appraisals did not take place, especially for non-clinical staff. This had already been identified as a priority area and action plans were in place to address this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: We found the registered provider did not operate effective recruitment procedures to ensure that staff were of good character, were physically and mentally fit for that work; and that information specified in Schedule 3 was available. This was in breach of regulation 21(a)(i)(ii)(iii)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19(1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.