

Trentside Medical Group

Quality Report

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Date of inspection visit: 3 November 2015

Date of publication: 18/04/2016

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Trentside Medical Group on 3 November 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Opportunities for learning were always considered and the practice adopted a candid and open approach.
- Risks to patients were assessed and well managed. This included staff and patient health and safety.
- Clinical audits had been carried out which demonstrated improved patient outcomes. One of the examples provided was a completed audit cycle.
- The majority of patients told us they were treated with compassion, dignity and respect. A wide variety of information and support services were made available to the public.
- The practice had offered extended hours appointments and had demonstrated flexibility in

response to increasing patient demand. However, patient feedback indicated that further measures were required so patients could more easily access the service and appointments.

- The practice had a number of policies and procedures to govern activity. Policies were reviewed, updated and accessible by staff.
- The practice had sought feedback from patients and had an active patient participation group.

The areas where the provider should make improvement are:

- Ensure that all staff have understanding of roles and responsibilities under the Mental Capacity Act 2005.
- Ensure safeguarding training is undertaken by all clinical staff within the practice and all staff are aware of their duties and responsibilities in relation to identifying and reporting potential safeguarding concerns.
- Ensure that the use of prescription pads is monitored within the practice.

Summary of findings

- Ensure that all staff undertaking chaperone duties receive formalised training to undertake their role.
- Records of action plans should be held when regular audits in infection control are undertaken.
- Ensure the management of staff training and record keeping in relation to the programme is strengthened.

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?

The practice is rated as good for providing safe services.

Good



- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were shared to ensure action was taken to improve safety in the practice.
- Risks to patients who used services were assessed and monitored. For example, up to date and accessible policies, medicines and vaccines handling and storage. The practice was equipped to deal with medical emergencies.
- When there were unintended or unexpected safety incidents, patients received a verbal and written apology where appropriate.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Care was delivered in line with current and relevant based guidelines which included National Institute for Health and Care Excellence. (NICE)
- The practice performance was performing in line with the national Quality Outcomes Framework (QOF) and was not identified as an outlier.
- A community care homes team nurse closely monitored practice patients in residential care homes and updated practice clinicians. This had assisted in the reduction of unplanned admissions into hospital.
- Staff worked with multi-disciplinary teams to coordinate the care of patients with multiple and / or complex health needs.
- Most staff received training appropriate to their roles. There was however, a lack of a robust approach in relation to the management and recording of training.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. However, not all staff could demonstrate that they had received training in relation to consent as outlined within the Mental Capacity Act 2005.
- There was evidence that clinical audits undertaken had an impact in relation to patient outcomes. We were shown evidence of one fully completed audit cycle.

Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- The majority of patients we spoke with and comment cards completed confirmed that people were treated with compassion, dignity and respect; and that they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained their confidentiality.
- Data showed that patients rated the practice similarly to local and national averages for several aspects of care. For example, patients had confidence and trust in the last GP they saw or spoke to and patients found the last GP they saw or spoke to was good at involving them in decisions about their care.
- However, some areas were identified as being lower than the local and national averages. This included whether or not last nurse a patient saw or spoke to was good at treating them with care and concern, and the helpfulness of receptionists.
- Information for patients about the services available was easy to understand and accessible. Information was targeted at people with a variety of different health concerns.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice had reviewed the needs of its population and had engaged with the Clinical Commissioning Group (CCG) and the NHS England Area Team to secure improvements to services where these were identified.
- The practice had implemented measures to respond to the increasing demand for patient appointments. This included extended hours surgery to accommodate patients of working age. The practice had also offered telephone triage appointments to assess patients. This had reduced the need for some patients to attend the surgery and created more appointments for those required to be seen on the day.
- The practice prioritised appointments for sick children and those urgently in need. It offered home appointments for those patients considered as vulnerable and unable to attend the practice.
- Patients could get information about how to complain. Complaints were addressed and taken seriously by the practice and lessons learned. Apologies were offered to patients where appropriate.

Good



Are services well-led?

The practice is rated as good for providing well-led services.

Good



Summary of findings

- It had a vision and a strategy and staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and staff we spoke with felt supported by management.
- The practice had a number of policies and procedures to govern activity. Policies were up to date and accessible by staff.
- The practice engaged with an active patient participation group (PPG). This had resulted in arrangements being made for public engagement between clinicians and the local community at topical health awareness events. The PPG had sought patient feedback and fed results back to practice management.
- Staff had received inductions, appraisals and were supported by management to undertake their roles. Management at the practice endorsed a no tolerance approach when reception staff had raised concerns about being treated aggressively by a minority of patients. This demonstrated management support for practice staff.

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

The practice is rated as good for the care of older people.

Good



- The practice had 757 patients aged over 75 on its register. The practice annually reviewed the records of patients not recently seen and checked if there were any health concerns which required patient contact. The practice had seen 734 elderly patients this year.
- Nationally reported data showed that outcomes for patients with conditions commonly found in older people such as osteoporosis were good and were significantly above the local and national averages.
- The practice had proactively engaged with the community care homes team nurse who regularly monitored the health needs of practice patients living in residential care homes.
- A care homes pharmacist employed by the CCG had started working with the practice to ensure safe and cost effective care home prescribing.
- The practice offered home visits and priority appointments for those with enhanced needs.

People with long term conditions

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

Good



- GPs and advanced nurse practitioners had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. For those people with the most complex needs, the named GP and nurse practitioners worked with the relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed.
- GPs provided clinical support where required to nursing staff who had roles in treating patients with long term conditions.
- The practice had recall systems in place for those patients with a long term condition.

Families, children and young people

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

Good



Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- We saw detailed records of joint working with midwives and health visitors. Meetings were held regularly to discuss risks to vulnerable patients.
- Immunisation rates were relatively high for all standard childhood immunisations and were in line with local averages.
- Whilst appointments were considered to be difficult to access at times, priority was given to sick children. These included lunch time appointments with the practice medical team. Appointments were also available outside of school hours and the premises were suitable for children and babies.
- The practice had attended a local comprehensive school in June 2015 to promote health awareness to students.

Working age people (including those recently retired and students)

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

- The age profile of patients at the practice in 2015 mainly comprised of working age persons 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 try and ensure these were accessible, flexible and offered continuity of care. Extended hours surgery was offered on weekdays which included appointments ranging from 7am to 7pm. Telephone triage appointments were also offered so that patients' health problems could be discussed. This negated the need for some patients to attend the practice for face to face consultations.

Good



People whose circumstances may make them vulnerable

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 those with a learning disability. There were 22 patients with severe learning disabilities and nine of these had received a health review, with the remainder planned for January to March 2016.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

Good



Summary of findings

- It had told vulnerable patients about how to access various support groups and voluntary organisations. The practice had referred a number of patients to a crisis intervention community support service run by the Red Cross. Information was also displayed within the practice waiting area.
- Most staff knew how to recognise signs of abuse in vulnerable adults and children. GPs 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)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia)

- The practice had attended two community events with the Alzheimer's Society which offered education to healthcare staff and carers of patients with dementia.
- Alzheimer's Society and Age UK had stalls on a monthly basis in the waiting room at the practice.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as Focusline and the Samaritans.
- The practice also encouraged those patients with mild to moderate mental health difficulties to self-refer to a therapy programme, Improving Access to Psychological Therapies (IAPT)

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was mainly performing under the local and national averages. 317 survey forms were distributed and 119 were returned. This represented a response rate of 37.5%.

- 66% found it easy to get through to this surgery by phone compared to a CCG average of 72% and a national average of 73%.
- 74% found the receptionists at this surgery helpful (CCG average 87%, national average 87%).
- 70% were able to get an appointment to see or speak to someone the last time they tried (CCG average 88%, national average 85%).
- 90% said the last appointment they got was convenient (CCG average 92%, national average 92%).
- 57% described their experience of making an appointment as good (CCG average 74%, national average 73%).
- 59% usually waited 15 minutes or less after their appointment time to be seen (CCG average 64%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards, 26 of which were all positive about the standard of care received. Four of these cards also included comments regarding lengthy appointment waiting times. Comments included that staff were courteous, respectful, patient focussed and that excellent care and treatment had been given. Receptionists were considered to be kind.

We spoke with seven patients during the inspection. All of patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. Three patients told us the appointment system was not easy to use as they were required to call on the morning of the day they needed an appointment and would prefer to pre book in advance. A parent told us that they had to take their child to school which meant they could not wait on the line to get through to make an appointment. We saw that one patient waited 30 minutes from their allotted appointment time to be called in. They were however, offered an apology for the waiting time.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff have understanding of roles and responsibilities under the Mental Capacity Act 2005.
- Ensure safeguarding training is undertaken by all clinical staff within the practice and all staff are aware of their duties and responsibilities in relation to identifying and reporting potential safeguarding concerns.
- Ensure that the use of prescription pads is monitored within the practice.
- Ensure that all staff undertaking chaperone duties receive formalised training to undertake their role.
- Records of action plans should be held when regular audits in infection control are undertaken.
- Ensure the management of staff training and record keeping in relation to the programme is strengthened.

Trentside Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist advisor, a nurse specialist advisor and a practice manager specialist advisor.

Background to Trentside Medical Group

Trentside Medical Group is located in Netherfield, a small town three miles east of Nottingham. The practice provides services for approximately 11,650 patients. There are areas of deprivation within the locality of the practice. The practice told us that they care for a high number of unemployed people, single parent families, patients with mental health problems and long term conditions such as those with lung diseases. The practice locality is within an ex mining area. They also told us that there are a high number of rental properties within the area which means a number of patients move in and out of the area more frequently.

The practice holds a Personal Medical Services contract (PMS) which is a locally agreed contract between NHS England and a GP to deliver care to the public. The practice provides GP services commissioned by NHS Nottingham North and East Clinical Commissioning Group (CCG).

The practice has a branch surgery located at Colwick. We did not visit the practice's branch surgery as part of this inspection.

The practice is managed by five GP partners. Three of the partners are male, working full time and two are female partners who work in part time roles. (0.75 Whole Time

Equivalent, WTE) They are supported by clinical staff; two female salaried GPs who work in part time roles, (both 0.59 WTE) two female advanced nurse practitioners, four practice nurses, two female healthcare assistants, and one male phlebotomist / trainee healthcare assistant. The practice also employs a practice management team which includes a business director, office supervisor and book keeper and a team of reception, clerical and administrative staff.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 7am to 6.30pm on Mondays, 8am to 6.30pm on Tuesdays, 7am to 7pm on Wednesdays, 7am to 6.30pm on Thursdays and 7am to 6.30pm on Fridays. The practice is closed during weekends. Urgent appointments are available on the day. Routine appointments can be pre booked in advance in person, by telephone or online. Telephone consultations and home visits are available daily as required. The practice also gives priority to sick children by offering dedicated lunch time appointments.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by Nottingham Emergency Medical Services. When the practice is closed, there is a recorded message giving the out of hours details.

The practice was a teaching practice for medical students.

The practice's Certificate of Registration issued by the Care Quality Commission lists three partnership members. We found that two other partners were working within the Practice. The Care Quality Commission (Registration) Regulations 2009 state that notice must be given to the Commission of any change in the membership of the partnership as soon as it is reasonably practicable to do so.

Detailed findings

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. The 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, unless stated otherwise.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the Clinical Commissioning Group, (CCG) care homes where some practice patients were residents, NHS England and HealthWatch. We carried out an announced visit on 3 November 2015.

During our visit we:

- Spoke with a range of staff, which included: four GPs, the Practice Manager, the Office Supervisor, the Reception Supervisor, two nursing staff, two health care assistants, administrative staff and we spoke with seven patients who used the service

- Observed how people were being cared for and talked with carers and family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 28 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager and relevant clinical lead of any incidents and there was also a recording template form available on the practice's computer system.
- The practice carried out an analysis of significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Clinical staff attended weekly meetings and discussed significant events, complaints and other incidents. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice took appropriate action when the routine checking of fridge temperatures showed a lower than expected recording. This resulted in Public Health England being consulted and the appropriate action taken. The practice staff showed us the national guidance they would refer to in the event of these occurrences. The practice had also purchased an additional fridge to ensure the required temperature of vaccines could be maintained as soon as they were delivered.

When there were unintended or unexpected safety incidents, people received truthful information, an apology and were told about any actions to improve processes. As a result of a flu vaccination error, the one affected patient was informed and reassured regarding the low level of risk involved. The member of staff undertook a lessons learned process to ensure the mistake would not be repeated.

Overview of safety systems and processes

The practice had some clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies outlined who to

contact for further guidance if concerns were held about a patient's welfare. We also saw contact details for the reporting of safeguarding concerns displayed in laminate in clinical treatment rooms.

- There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. We checked patient records had been marked accordingly if they were considered at risk. GPs were trained to level three safeguarding for children.
- We found that whilst most staff demonstrated they understood they had responsibilities regarding safeguarding, we were not assured that all staff had received safeguarding training at the practice relevant to their role. We presented a scenario to one staff member regarding what action they would take in the event of a safeguarding concern and they were unsure of the arrangements in place.
- A notice in the waiting room advised patients that chaperones were available, if required. All staff who acted as chaperones had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were informed that staff who acted as chaperones had not received formalised training to undertake this role but staff we spoke with did demonstrate understanding of their responsibilities).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken training to deliver her role. We spoke with the Clinical Commissioning Group (CCG) local infection prevention team who told us they were aware of a self-audit the practice had undertaken in March 2014 but their records did not show any more recent liaison had taken place.
- We saw evidence that an infection control audit had been undertaken but we did not see an action plan implemented to address any issues identified. The infection control lead told us that they had however rectified any issues which were identified at the time, for example, hand rub was replaced in areas identified.
- There was an infection control protocol in place and staff had received some training. We found a lack of

Are services safe?

structured approach in relation to the management of staff training and record keeping in relation to the programme. This impacted on the practice's ability to monitor ongoing effectiveness and completeness of staff training.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). We found that blank prescription pads were securely stored but not monitored in respect of the number of pads held and their sequential numbers. We checked in one of the doctor's briefcases and found control information was recorded however. This included sequential numbers on prescriptions used. Following the inspection the practice told us that additional measures had been put in place.
- The practice carried out medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The Clinical Commissioning Group (CCG) told us the practice was actively engaged and informed us about a medicines review of learning disability patients undertaken and a review of antibiotic prescribing due.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw evidence that the practice had a system for the production of Patient Specific Directions to enable health care assistants to administer vaccinations.
- We reviewed four personnel files which included documents which related to two locum doctors. We found that appropriate recruitment checks had been undertaken prior to employment for two permanent members of staff, which included references, qualifications and registration with the appropriate professional body. Disclosure and Barring Service checks (DBS) were held on these two files, one of which had been applied for by the practice at the time the applicant had been offered the post. One of the members of staff had supplied an existing DBS certificate which had been accepted without the practice submitting a new application. We noted however, that this DBS check was dated a month prior to when the staff member commenced work at the

practice. Two locums had been infrequently utilised by the practice. We found records of registration with the General Medical Council showing their licence to practice, proof of identification and references.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. We saw evidence of drills that were conducted in November 2014 and June 2015. Equipment such as wheel chairs were available to patients who would require assistance in the event of an emergency.
- We found electrical and clinical equipment was checked to ensure it was safe to use and these checks were undertaken on an annual basis.
- The practice also had risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health and infection control and legionella. We saw evidence that a risk assessment had taken place in September 2015 and water temperature recording checks had taken place in October 2015.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All of the staff we spoke with told us that staff covered shifts for each other when required and full time GPs took on extra workload to ensure their part time colleagues work commitments were met. A small number of locum doctors had been used on previous occasions when required.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant panic button system in use on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received basic life support training, with the most recent undertaken in October 2015.

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. We saw evidence of documented meetings where clinicians attended and this guidance was discussed. Staff had online access to guidelines from NICE online and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.8% of the total number of points available, with 11.9% exception reporting. The practice's exception reporting was above the CCG average by 2.8% and above the national average by 2.7%.

(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance for diabetes related indicators was 89.7% which was comparable to the clinical commissioning group (CCG) average of 87.3% and national average of 89.2%. The practice exception rate reporting was however above the CCG average in nine of the related indicators and above national average in eight of the indicators. This varied from 0.5% to 38.5% across the indicators.
- The percentage of patients with hypertension having regular blood pressure tests was 91.9% which was

comparable to the CCG average of 85.5% and national average of 83.6%. The practice exception reporting rate was 3.6% above CCG average and 3.9% above national average.

- 94.5% of patients diagnosed with a mental health condition had a documented care plan in place in the previous 12 months. This was comparable to the CCG average of 86.4% and national average of 88.3%. The practice exception rate reporting was again above CCG average by 7.1% and above national average by 13.1%.

We reviewed data which showed the practice was third highest out of 21 within the local Clinical Commissioning Group (CCG) for patient attendance at minor injuries units and walk in centres between April 2015 to July 2015. It was also the sixth highest for patient attendance at the Accident and Emergency department (A and E) between April 2015 to July 2015. The practice told us that their practice was close to an Accident and Emergency Department which they said may have had an impact on higher attendance rates. We reviewed evidence of clinical meeting minutes which demonstrated that the practice had identified inappropriate usage of Accident and Emergency department and had sought to address this with the patients identified.

A sample of clinical audits reviewed demonstrated some quality improvements were made. We reviewed documentation which related to three clinical audits which were conducted in 2014 and 2015. Two of these were incomplete audits, as two full cycles had not been conducted. The practice was able to demonstrate some procedural changes since the initial audits in two of the examples provided. This had a positive benefit for some of the practice patients.

An audit was conducted in March 2014, on patients who were prescribed with disease-modifying anti rheumatic drugs (DMARDs). DMARDs are a group of medications commonly used in patients with rheumatoid arthritis. They work to decrease pain and inflammation, to reduce or prevent joint damage, and to preserve the structure and function of the joints. After outcomes were identified in the initial audit, a further review took place four months later which evidenced an improvement in all tested standards following the adoption of audit findings.

Are services effective?

(for example, treatment is effective)

We were shown an audit which had taken place of minor surgery by one of the GP partners. The audit had completed one cycle. We were not shown evidence to demonstrate that learning outcomes had been disseminated and shared with the practice.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as infection prevention and control, fire safety, health and safety and confidentiality. This was supported by evidence we reviewed in staff files.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Protected learning time was given to staff to complete mandatory training. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff were appraised annually.
- The practice could demonstrate that they provided some role-specific training and updating for relevant staff, for example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. This was supported by our discussions with clinical staff. Staff also followed a programme of e learning which was assigned to them.
- However, we found that there was inconsistent monitoring and documentary records of this learning. We were told that a more coordinated and centralised approach was being developed.
- Staff received training that included: fire procedures, basic life support and information governance awareness.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team and palliative care meetings took place on a three monthly basis. We saw that care plans were routinely reviewed and updated. The practice informed us that they were in the process of increasing the frequency to monthly meetings. We reviewed detailed minutes from meetings held which supported the collaborative working.

The Clinical Commissioning Group (CCG) employed a care home nurse who was attached to the Community Care Homes team to work with patients of the practice living in care homes. We were told by the practice and the CCG that this had significantly reduced unnecessary admissions of patients into a hospital environment and ensured patients nearing the end of their life received a high standard of care. We spoke with the practice and the Community Care Homes team nurse who told us that they regularly met and reviewed the individual needs of patients. This was as part of the Golds Standards Framework for end of life care. The national gold standards framework helps clinicians provide the highest possible standard of care for all patients who may be in the last years of their life. The Community Care Homes team nurse told us that GPs within the practice provided an excellent and responsive service when any individual patient concerns were identified. One of the care home managers we spoke with stated the practice was very responsive. Another care home manager told us that whilst historically they had found the practice had not engaged, the Community Care Homes team nurse had successfully bridged a gap in communications.

Consent to care and treatment

Most staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinical staff we spoke with including GPs and nurse practitioner understood the relevant consent and

Are services effective?

(for example, treatment is effective)

decision-making requirements of legislation and guidance. However, we found a lack of training in relation to the Mental Capacity Act 2005 for some staff. We were told that advanced nurse practitioners had attended this training but learning outcomes had not been disseminated to all of the team. A member of nursing staff we spoke with did not demonstrate an understanding of the Mental Capacity Act 2005 when presented with a scenario and asked what action they would take in the circumstances.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Health promotion and prevention

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Information was available on the practice's internet page which included a dedicated area for teenage health concerns. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group and was also offered to patients during clinical consultations.

QOF Data for 2014/15 showed the practice's uptake for the cervical screening programme was 83.8% which was 2.4% below the CCG average but 2% above the national average. There was a policy in place to send reminder letters to patients by recorded delivery if they did not attend for their cervical screening test. Non-attenders would then have an alert placed on their records for clinicians to discuss when they next saw the patient.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data supplied by the practice indicated that within the previous six months from November 2015;

- Patient uptake for bowel cancer screening was 48.8%. This was below the CCG average of 60% and national average of 55.4%.
- 77.5% patients at the practice had undertaken screening for breast cancer. This was comparable to the CCG uptake of 80.2% and higher than the national average of 73.2%.

Childhood immunisation rates for the vaccinations given from 1 April 2014 to 31 March 2015 to children two years old and younger were in line with or exceeded the CCG averages according to QOF data. For example;

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.6% (91.7% in CCG) to 98% (96.5% in CCG) excluding Meningitis C which was 0% in the practice and 1.4% in the CCG. Five year olds ranged from 86.8% (88.1% in CCG) to 100% (98.1% in CCG)

Data supplied by the practice showed that in 2013/14;

- Flu vaccination rates for the over 65s were 75.07%. This was comparable to the CCG uptake of 73.5% and higher than the national average of 72.98%. At risk groups take up was 49.84%, comparable to the CCG uptake of 50.8% and lower than the national average of 53.23%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff we spoke to told us they could speak to patients in a separate and a more private area if patients wanted to discuss sensitive issues or if they appeared distressed.

We found that 26 of 28 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a member of the patient participation group (PPG) They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. They found practice staff approachable and co-operative. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients generally felt they were treated with compassion, dignity and respect. The practice had similar or lower than local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 82% said the GP gave them enough time (CCG average 86%, national average 87%).
- 94% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%)

- 80% said the last GP they spoke to was good at treating them with care and concern (CCG average 84%, national average 85%).
- 83% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 90%).
- 74% said they found the receptionists at the practice helpful (CCG average 87%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care (CCG average 81%, national average 81%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice's website included google translate so information could be read in many different languages.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room informed patients how to access a number of support groups and organisations. These included Age UK, Alzheimer's Society, support for new mothers, victims of assault support, child exploitation support and help for those with cancer.

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. During our inspection, we found reception staff did not have access to see these alerts on carers' records if they telephoned to make an appointment. We discussed this with the practice. We were told after our inspection that this had been changed so reception staff could now see alerts if a carer telephoned to make an appointment. This would now ensure reception staff could book longer appointment times if required.

The practice had identified 262 carers on their list. This represented 2.24% of patients registered at the practice. A wide variety of written information was available within the practice to direct carers to the various avenues of support available to them.

Palliative care meetings held regularly within the practice highlighted individual patients and their current state of health. One of the GPs told us that if families had suffered bereavement, they would contact them to provide necessary support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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.

- Extended hours appointments were available to meet the needs of working age people.
- The practice had been trialling a walk in clinic on Monday and Thursday mornings, where patients could sit and wait to be seen by a clinician. This was introduced because of high patient demand routinely required at this point of the week. At the time of our inspection, the walk in clinic had not been widely publicised to patients.
- The practice had introduced telephone triage where a GP or Nurse Practitioner would telephone a patient back after they had called the practice for advice. The practice told us this had been well received with working age people in particular and had negated the necessity for many patients to attend the practice in person.
- Priority appointments were given to children and those with serious medical conditions who would be offered an appointment on the same day.
- Home visits were available to older patients who had long term conditions and other patients considered as being vulnerable. The practice told us this provided the clinicians with insight as to the patient's requirements and the existing support and care available in their homes.
- The practice had an agreement with Age UK and the Alzheimer's Society to have a stall in the surgery on a monthly basis. This helped signpost vulnerable and elderly patients to services available to them.
- GPs within the practice attended local community centre events organised by the practice's Patient Participation Group (PPG). The PPG is 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 events were to help raise awareness of dementia and to offer support and advice to patients in need.
- British Red Cross provided a Crisis Intervention Community Support Service to support vulnerable

adults in times of crisis. This was a service commissioned by the Clinical Commissioning Group (CCG) and had directly benefitted some of the patients registered at the practice. We obtained data from the Clinical Commissioning Group (CCG) which showed that from April to June 2015, 7 patients registered at the practice had been referred to the service by GPs, district nurse, nurse practitioner and community Macmillan nurse.

- The practice had attended a local secondary school event held in June 2015 to deliver health promotion and prevention advice to young people. This was an annual event.
- Facilities for patients with disabilities and translation services were available. Reception staff provided additional assistance to those who had hearing difficulties.

Access to the service

The practice was open Mondays to Fridays between 8am and 6.30pm. Appointments were from 7am to 6.30pm on Mondays, Thursdays and Fridays, 8am to 6.30pm on Tuesdays and 7am to 7pm on Wednesdays. The practice was closed at weekends.

In addition to pre-bookable appointments that could be made a few days in advance, online appointments could be booked and urgent appointments were available for people that needed them.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was lower than local and national averages.

- 66% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 66% of patients said they could get through easily to the surgery by phone (CCG average 72%, national average 73%).
- 57% of patients described their experience of making an appointment as good (CCG average 74%, national average 73%).
- 59% of patients said they usually waited 15 minutes or less after their appointment time (CCG average 64%, national average 65%).

Are services responsive to people's needs?

(for example, to feedback?)

Three out of seven patients we spoke with were satisfied with the appointment system including the availability of routine appointments. Four patients we spoke with on the day told us that it was difficult to get an appointment when needed. They told us that they had to wait to get through to a receptionist, and would often be told that there were no appointments available or to try later in the day or the following day. A family told us that when they called the practice at their opening time of 8am, they were not able to wait in a lengthy queuing system because they needed to take their children to school.

Patient feedback was reviewed from NHS Choices. We looked at 13 reviews which were mixed. Positive comments we reviewed included that the telephone appointment system was good and responsive and there had been improvements made. Negative comments included patient dissatisfaction with the appointment system.

The practice told us that they intended to move premises to larger accommodation by the Summer of 2017. They told us this would provide better services and facilities for patients and staff as they were at present constrained in the existing smaller building at Netherfield. They told us that this limitation had had an impact on offering appointments at peak times. The practice also told us they worked flexibly to facilitate patient requirements.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- The practice placed information about its complaint process on its website and at the reception desk.
- There was a designated responsible person who handled all complaints in the practice.
- There was a form available at reception for patients to record written complaints. The form stated that the office supervisor would make contact with the patient to discuss details of the complaint. The form did not include information about external organisations which could be consulted if the patient remained unhappy about how their complaint had been addressed.
- Complaints made were discussed at practice management meetings and learning outcomes identified.

The practice recorded 14 complaints which were received in the last 12 months. The practice demonstrated that it addressed all complaints seriously and tried to ensure appropriate action was taken to resolve concerns raised.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for all patients, regardless of their age, sex, race, disability or language barrier. The practice acknowledged existing limitations in its premises. Their strategy was to develop into a primary care centre which included working with third sector organisations, providing an educational unit and thereby creating a state of the art facility.

The practice had vision and values which were regularly monitored. Staff we spoke with were aware of the vision and values.

Governance arrangements

The practice had a governance framework in place.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented, reviewed and were available to all staff. Staff we spoke with knew where to locate policies if needed.
- Staff had an understanding of the performance of the practice. We saw evidence that performance of the practice was reviewed and discussed amongst the clinicians for example, monitoring of QOF performance data.
- A programme of clinical and internal audit which was used to monitor quality and to make improvements in care. We saw evidence of this within an audit undertaken in disease-modifying anti rheumatic drugs (DMARDS).
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. These included significant events.
- We found however, that systems and processes regarding the management and recording of training needed further strengthening to ensure a robust approach adopted.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality

care. They prioritised high quality and could demonstrate some compassionate care. The partners were visible in the practice and staff told us that they were approachable and take the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for reporting notifiable safety incidents. We found there was an open culture amongst staff to inform management of any errors made or to express their concerns. We reviewed action taken by the practice where a clinical error was made by a member of staff. Learning points were noted by the member of staff and they received additional training as a measure to reduce the risk of the error being repeated.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology. This was demonstrated in the subsequent action which took place when the clinical error we reviewed was brought to management's attention.
- They kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff told us they felt supported by management.

- Staff told us that the practice held regular team meetings. We saw records relating to weekly practice meetings held.
- Staff said they felt respected and supported by the partners in the practice. The practice reception staff had been subject to aggressive behaviour by a minority of patients. GPs had addressed this directly with some of the patients concerned and informed them of consequences to their actions, such as removal from the practice list. These events were also recorded in incident logs and discussed with staff.

Seeking and acting on feedback from 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)

The practice reviewed feedback from patients, the public and staff. It sought patients' feedback and responded when it was both positive and negative. The practice invited those leaving feedback to join the patient participation group (PPG).

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was a small but active PPG which met on a regular basis, by face to face meetings, telephone and email.

- Proposals for improvements were discussed with the practice and PPG during meetings held. These included patient concerns regarding the appointment system and the practice response to release more on the day telephone appointments. The PPG helped to promote practice news and topical health information through its newsletter produced for patients.
- Staff told us their feedback was welcome within the practice. This could be provided in meetings and annual appraisal.