Winterton Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Winterton Medical Practice on 10 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the 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 and people experiencing poor mental health (including people with dementia). We found the care of older people to be outstanding.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

• Risks to patients were assessed and well managed.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• 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.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

Summary of findings

The practice provided a community geriatric service which was led by a consultant Geriatrician and supported by a physiotherapist. The aim of the service was to focus on dealing with conditions associated with ageing and the frailty of old age. The practice also provided a falls community assessment clinic and patients who were on the end of life pathway were appointed a named GP who managed their care.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. We spoke with staff in the dispensaries at both surgeries and saw that they dispensed medication in a well organised and safe way. There was enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. We saw that regular staff appraisals were undertaken and all staff were aware of their roles and responsibilities. We saw evidence of good multidisciplinary working and links to local community groups.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team to secure improvements to services where these were identified. The practice was part of a local GP federation which works together with other practices sharing responsibilities for delivering high quality care for their local communities.

Summary of findings

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. We saw that the practice offered a range of general surgical and orthopaedic surgery. These were provided by the practice and consultant surgeons. The practice had a fully developed theatre suite within the practice.

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 with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice is a teaching practice and actively involved in research within the practice.

There were a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice were also using the PGP toolkit to review and improve the quality of services provided by the practice.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice had a high number of older people particularly attending the branch surgery. They offered proactive, personalised care to meet the needs of the older people and had a range of enhanced services, for example, in dementia and end of life care.

The practice provided a community geriatric service which was led by a consultant Geriatrician and supported by a physiotherapist. The aim of the service was to focus on dealing with conditions associated with ageing and the frailty of old age. Care plans were developed by the GP, Geriatrician, patients and carer/family. We saw evidence of good links to the community matrons, and local care and nursing homes.

The practice also provides a falls community assessment clinic which is run by the physiotherapist and Geriatrician. Patients can access this service in their own homes, the surgery and the local care /nursing homes. The aim of the service is reduce the risk of falls and fractures which will assist in reducing the pressure on accident and emergency (A&E) and secondary care.

The rural location of the practice meant that many older people were living in isolated areas with poor access to public transport. The practice worked with the local community to promote good health and improve access to services for older people. Examples of this were the winter health tool kit and the Winterton care campaign winter support scheme for people over Sixty. This provided people with a survival kit, advice and support.

Each older patient had a named GP and received over 75 health checks. District Nurses, Community Matrons and Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

People with long term conditions

Good ●

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP, nurse

practitioner or practice nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care. Each patient on the palliative care register list were assigned a named GP to oversee their individual care and arrange three monthly multiagency palliative care meetings.

Access to in house physiotherapy is available to all patients suffering from Long term conditions.

Families, children and young people Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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.

We saw good examples of joint working with midwives, health visitors and school nurses. Pregnant mothers are also invited to attend the surgery to have their pertussis and flu vaccination. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. The practice offered a family planning service at the practice.

Working age people (including those recently retired and students) Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Patients can book appointments twenty four hours a day using the practice automated system. Appointments are available up to 6 pm, there are no current extended hours offered at the practice. The practice were regularly monitoring patient's satisfaction with accesses to appointments which currently demonstrate a high level of satisfaction.

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

those with a learning disability. It had carried out annual health checks for people with a learning disability and when required these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice provided care into local care home for people with learning disabilities. The GPs attend the home to see patients and complete their annual review. There is a named GP for learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. All patients diagnosed with Dementia were offered an appointment with the GP to discuss and agree a care plan to meet their individual needs. All clinical staff had completed mental capacity and Dementia training.

Patients had access to clinics within the practice for depression and those requiring further support. The practice also provided support to a care home that looked after patients suffering from mental illness. These patients were regularly reviewed by the GPs their needs assessed and care plans established. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 24 completed CQC comment cards. We spoke with three patients who were using the service on the day of inspection. We spoke with a range of patients from different age groups and with different health needs. We also spoke with three members of the patient participation group. All the patients we spoke with were complimentary about the service. They told us they found the staff to be caring, supportive, and provided them with a consistently high level of care.

Patients were aware they could have someone present at their consultation if required and were able to speak to staff in a private area if necessary. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

We saw that the practice were continually seeking feedback from patients to shape and develop services in the future. We saw that patient views were listened too and the results of patients surveys reviewed and shared with patients. We saw that the NHS survey results for the practice were displayed in the December 2014 patient's newsletter. The percentage of patients rating their ability to get through to the practice on the phone was 89%, and 87% of people rated their overhaul experience of making an appointment as good. The proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good was 91%. Patients we spoke with commented that they felt supported, listened to by staff and not rushed during their consultations.

Patients we spoke with commented that they felt supported and listened to by all staff. We observed a friendly relaxed environment between staff and patients.

The practice had established a positive and proactive patient participation group (PPG). The PPG representatives met every three months to discuss the service and look for ways they could work with the practice to improve the service. There was also a virtual group where members could be consulted and share information online. The PPG had been responsible for a range of initiatives and changes, for example conducting patient surveys. In June 2014 they participated in PPG awareness week. During this week members of the group attended both surgeries to gather feedback on how services could be improved. The group asked one question of patients, 'how satisfied are you with the care and safety you receive from the practice. In Winterton 81% were very satisfied and in the branch surgery in Burton 92% were very satisfied.

In the waiting area of each practice there were dedicated PPG notice boards which provided information to patients about the work and initiatives undertaken by the group.

We found that the practice valued the views of patients and saw that following feedback from surveys changes were made in the practice.

Outstanding practice

We saw that the practice were outstanding in the care of older people

The practice provided a community geriatric service which was led by a consultant Geriatrician and supported by a physiotherapist. The practice also provided a falls community assessment clinic and patients who were on the end of life pathway were appointed a named GP who managed their care.

Winterton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist adviser, CQC inspector and a specialist practice manager.

Background to Winterton Medical Practice

Winterton Medical Practice delivers general medical service (GMS) under a Contract between themselves and NHS England. They are part of a local GP federation with other practices in the area and the federation practice is known as Safecare. There are five GP partners and one salaried GP, three female and three male. The practice also has access to regular locums. The practice currently provide 46 sessions per week. They currently have one GP vacancy.

The practice delvers services to Winterton village and surrounding villages areas. There is a branch surgery located in Burton Upon Stather. The practice provides services to 9700 patients of all ages. We visited the main surgery and branch surgery dispensary as part of the inspection.

The practice is a teaching, training and research practice, there is currently one GP registrars working in the practice and one due to start in February 2015. There are two GP trainers in the practice and another two GPs involved in the training of medical students.

The practice holds a contract with NHS North Lincolnshire CCG to provide surgical and orthopaedic service within the practice. There is a fully equipped surgical suite suitable for day surgical cases. Examples of some the procedures undertaken are vasectomy, rigid sigmoidoscopy, carpel tunnel release, lower leg varicose veins and trigger finger release.

Patients can book appointments face to face, by the telephone or online. The practice treats patients of all ages and provides a range of medical services. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service via 111 when the surgery is closed and at the weekends. In emergency patients are advised to ring 999 or attend the nearest accident and emergency department.

There is an all-female nursing team of two advanced nurse practitioners and three practice nurses and a theatre nurse. The team are supported by health care assistants and dispensers. The nurses promote healthy living; provide support for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The practice has car parking facilities and access for the disabled. There are links to public transport.

There were no previous performance issues or concerns about this practice prior to our inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal

Detailed findings

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.

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?

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)

For example:

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked NHS North Lincolnshire and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 10 February 2015. During our inspection we spoke with the staff available on the day. This included three GPs, nurse practitioner, health care assistant, theatre nurse, the practice manager, assistant manager, four dispensary staff and four administration staff. We also spoke with three patients who used the service and three member of the patient participation group.

We reviewed 24 CQC comments cards which had been completed where patients and members of the public shared their views and experiences of the service.

We observed the interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example practice has a specific form to raise safety concerns and all issues raised are investigated.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Learning and improvement from safety incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the year and we were able to review these. Significant events were a standing item on the practice clinical meeting held every two weeks. We saw regular review of actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. We saw that there had been 25 significant events recorded from February 2014 until Jan 2015. Staff including, dispensers, administrative and nursing knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff told us they would always raise any concerns or risks with the practice manager or assistant manager in person. We saw that the practice also had a nominated safety lead who monitored safety and risk within the practice. We saw evidence of action taken as a result of an issue raised. An example of this was that all messages should be sent as tasks to ensure everything discussed verbally was actioned.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. An example given by staff was the recent Ebola information.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding and the mental capacity act. 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 and out of normal hours working hours. Contact details were easily accessible on the practice computer system.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained at level three and could demonstrate they had the necessary training to enable them to fulfil this role. The lead was aware of all safeguarding concerns raised within the practice. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The practice had regular staff meetings to discuss urgent concerns regarding patients.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, and chaperone notices which were visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, the receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The practice were able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children (under care of the Local Authority).

Good

Are services safe?

The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up with letters and discussed with the Health visitor. The practice had access to a named Health visiting team as part of the PMG.

We saw that staff were aware of and responsive to older people, families, children and young people, vulnerable people and the support they may require. The practice had good awareness of the support organisations within the local community and surrounding areas.

The practice had processes in place to identify and regularly review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GPs.

The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police, social services and support organisations.

Medicines management

Arrangements for managing medicines were checked at the surgery and branch surgery. Medicines were dispensed for patients who did not live near a pharmacy. Staff told us that people who were eligible had the choice of having their medicines dispensed at the surgery or their local pharmacy. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Staff showed us the standard operating procedures (these are written instructions about how to safely manage medicines) and we saw they covered all areas. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors.

The practice had a safe system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted promptly to GPs who made the necessary changes to patients' records.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

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 storage and recording of blank prescriptions should be reviewed to ensure that there was an appropriate audit trail of blank prescriptions. This ensures that there is no diversion or misuse of prescriptions that could go undetected.

We saw a system was in place for managing national alerts about medicines such as safety issues. Records showed the alerts were distributed to dispensers, who implemented the required actions as necessary to protect people from harm.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. However the records for receipt and dispensing of controlled drugs were kept in ring binders which increased the risk that they could be removed or misplaced. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

We saw records showing all members of staff involved in the dispensing process had received appropriate training.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who was supported by the nurse practitioner and who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out regular audits and that any improvements identified for action were completed on

Good

Are services safe?

time. We saw that the lead observed all clinical staff whilst undertaking hand washing to observe their technique and to ensure they followed procedure. Over the year all staff were observed and any areas of concern with the competency of technique were addressed. 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.

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. We saw that there were also separate procedures in place for the dedicated theatre suite in the practice which was monitored by the theatre nurse.

There was a policy for needle stick injury in place within the practice which staff were aware of.

The practice had a policy and risk assessment in place for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

However we saw that in the waiting areas on the corridors two chairs were fabric and badly stained. This could lead to cross infection between patients. We also found a plug in the sink of one of the consulting rooms. Plugs are not recommended in these areas to prevent the harbouring of infection.

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 and patient monitoring equipment were regularly tested.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place to ensure that enough staff were on duty.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager continually monitored the staffing levels to ensure staffing levels and skill mix was in line with planned staffing requirements. We were told that currently the practice had a vacancy for a GP which they are hoping to recruit shortly. The practice when possible uses two regular locums who are familiar with the practice and the patients.

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 and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and a named Health and safety lead. Health and safety information was available to staff on the practice computer system.

Identified risks were included on a risk log. Risks were assessed and mitigating actions recorded to reduce and manage the risk. We saw that risks and concerns were discussed at the practice meetings. For example ensuring patient specimens were handled and disposed of correctly.

Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. We saw that for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. The nurses we spoke with told us that if a patient's condition is deteriorating they would increase the frequency of appointments and discuss with the named GPs. We saw that were there were concerns about a

Good

Are services safe?

patient's condition they could be discussed and advice obtained from other clinicians. We saw that there were regular meetings held in the practice and that the GPs met up to discuss issues daily over a planned coffee break.

There were emergency processes in place for identifying acutely ill children and young people, and staff gave us examples of referrals they made. The practice had appropriate equipment in place to deal with medical emergencies for all patient groups.

We saw information on the practice web site and in the waiting areas explaining what patients who are experiencing a mental health crisis should do to access emergency care and treatment. The practice also hold special clinics in the surgery for people suffering from depression or requiring further support and intervention.

The clinical staff told us they actively assess patients for dementia to ensure they are diagnosed and offered the treatment and support they require. Patients diagnosed with Dementia are offered an appointment with a GP to discuss and agree a care plan that meets their needs.

The practice monitored repeat prescribing for people receiving medication for mental health needs and this was scheduled as part of their annual review. We saw that education sessions had been held to raise awareness to GPs of avoiding dependence of certain medication in patients.

Arrangements to deal with emergencies and major incidents

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

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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the power failed.

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

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 and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw evidence that GPs and nurses had processes in place to continually update their knowledge and skills. Examples of these were attending the Clinical Commissioning Group (CCG) education sessions and attending external courses

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice nurses provided daily clinic in these areas and patients were able to book directly with the nurse. For example, for appointments for asthma and diabetic reviews.

We saw that a nominated GP attended the CCG monthly meeting on behalf of the practice. The practice undertakes an internal peer review of referrals and also bench mark this with the neighbouring practices. We saw that care plans had been developed for patients with complex needs. These were reviewed at the practices clinical and multidisciplinary meetings.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice told us they did not use choose and book referral system currently to refer patients into secondary care. The lead GP told us they had used this process in the past but had stopped as patients tended to always go to the same hospital. We saw that the practice have a paper checking system in place to ensure good compliance with this system. All GPs are regularly sent a copy of the referral rates and are peer reviewed internally. We saw that there were processes in place for patients with suspected cancers who were referred to secondary care and seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making**.**

Management, monitoring and improving outcomes for people

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

The practice has a comprehensive audit record and most of the audit cycles have been completed. We looked at two clinical audits that had been undertaken in the last two years. The two audits we looked at were Lower Back pain and use of the appropriate use of certain medicines. Other examples of audits undertaken included audits to of cancer referrals and management and diagnosis of urinary tract infections.

We saw that the practice had taken action following these audits. For example in the audit of lower back pain we saw the all practitioners reviewed the NICE guidelines on the management of lower back pain LBP and reviewed their current practice. This showed 24% of patients were referred for radiographs as per guidelines. Following the re audit, number of radiographs performed had reduced. However it also highlighted a need to discuss NICE guidelines with GP registrars and locums at induction and provide a copy of the guidelines in the induction folder as reference.

The GPs told us clinical audits were often linked to medicines management information, safety alerts, and significant events or as a result of information from the quality and outcomes framework (QOF). The QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of medicines. Following the audit, the GPs carried out medication reviews

Good

Are services effective?

(for example, treatment is effective)

for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients who are current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months was 95%. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and dementia. This practice was not an outlier for any QOF (or other national) clinical targets**.**

The team was making use of clinical audit tools, clinical research, and 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 that there was an expectation that all clinical staff should undertake or be involved in the audit process.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw that each palliative care patient was managed by a nominated GP who monitored their care needs and treatment.

The practice participated in local benchmarking. 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.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensary and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas or qualifications. Examples of these are sexual and reproductive medicine, surgery and the training of GP registrars. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example long term conditions. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We were unable to speak with the GP registrar on the day of inspection who was training.

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, cervical cytology and manage long term conditions. Those with extended roles seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was an incident reported in the last year were a pathology result had not been discussed with a patient. The practice discussed this matter at the clinical meeting and ensured systems were put in place to prevent this reoccurring.

Good

Are services effective?

(for example, treatment is effective)

The practice was commissioned for several enhanced service. Examples of these are ensuring pregnant women are offered the Pertussis vaccination, dementia identification and unplanned admissions. We saw that the practice had systems in place to manage and learn from unplanned admissions. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the practice had developed policies and procedures to deal effectively with the enhanced services and regularly monitored this.

The practice held multidisciplinary team meetings every six weeks to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the clinical and the patients care teams instant access to medical records at this surgery and the branch surgery. This system enabled staff in the practice to see and treat patients within the practice. These 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 in place to provide staff with the patient information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Hospital discharge letters were mainly electronic and were coded and seen by a doctor. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had processes in place to help staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all surgical procedures consent was recorded. We saw that a blank consent form was sent out to patients with their letter providing information about their forthcoming operation. The patient is then able to ask any questions of the surgeon before they sign the consent form on the day of the operation.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice asks new patients to complete a new patient registration form and there is a separate form for children. The practice may then invite patients in for an assessment with one of the clinical staff. The registration form is detailed and asks the patients if they require medicines to

Good

Are services effective?

(for example, treatment is effective)

be dispensed, if they are currently receiving hospital treatment and details of their family history. Patients were also asked if they have a preferred GP they wish to be registered with and see. However patients were informed that asking to see a named GP could involve a longer wait for an appointment. The GPs were informed of all health concerns detected and these were followed up in a timely way.

We were told that GPs and nurses use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic screening to patients, offering health promotion advice such a weight management and smoking cessation.

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 offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80%, which was average nationally. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders in the practice, these were also discussed with the Health Visitors.

The practice kept a register of patients who were identified as being at high risk of admission, or at End of Life and have up to date care plans in place for sharing with other providers. All patients on the practice 'at risk 'group were offered appointments with their named GP to discuss and agree their care plans. Patient care plans are reviewed every three months to ensure they continued to meet the patient's needs. The GPs, nurse practitioner, community matron and practice manager meet every month to review the register. They also review admissions to hospital and Accident and Emergency to establish if anything could have been done to prevent attendance.

We saw that patients in this group were followed up after admissions and the practice used resources available to prevent readmission. We saw that people received regular structured annual medication reviews for polypharmacy. All patients over 75 had a named GP.

People with long term conditions received a structured annual review for various long term conditions (LTC). Examples of these are Diabetes, COPD, Asthma and Heart failure. The percentage of patients with diabetes, on the register, who have had influenza immunisation, was 97%.

The clinical staff we spoke with told us they provided health promotion and lifestyle advice. We saw good information provided in the practice and on the practice web site with links to health promotion on the NHS Choices site. There are also links to a range of assessments such as alcohol screening. We saw that the practice promoted such activities as healthy walking groups locally.

We saw that the practice regularly reviewed and monitored patient records using the electronic patient records. Examples of these were monitoring new cancer diagnoses, annual reviews with medicines management and cervical screening final non responders. We saw that the practice regularly monitored the palliative and safeguarding registers which were discussed at the clinical and multidisciplinary management meetings.

There were comprehensive screening and vaccination programmes which were managed effectively to support children and young people. Staff were knowledgeable about child protection and safeguarding. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

The PPG had recently contacted the local secondary school to try and engage with young people to discuss how and what services they would like to access. The practice were keen to ensure they provided access to services that were user friendly to young people and provided good information and access.

The practice provided services that were accessible to working age people. The practice offered services up until 6

Good

Are services effective?

(for example, treatment is effective)

pm with the GP and patients could also access appointments with the nurse practitioners. The practice have submitted a bid as part of the GP federation for financial support to establish out of hours surgery sessions. The practice told us they were also looking at consulting with working age adults about what access they would find useful.

We saw that the practice were aware of people whose circumstances may make them vulnerable. The practice holds a register of those in various vulnerable groups such as learning disabilities.

People experiencing poor mental health in the practice had access to services. We saw that people with severe mental health problems received an annual physical health check.

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 national patient survey, which the practice had shared with patients. The PPG were also active in supporting patient's surveys and in June 2014 the group participated in the PPG awareness week. During this time they had been involved in gathering feedback from patients that could improve services. The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with professionalism, compassion, dignity and respect. For example, data from the national patient survey showed the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was 91% which is above the national average.

We saw that following patient surveys and discussion with the PPG the practice agreed an action plan and priority areas for the year. Examples of these priority areas were improving the use of text reminders to patients regarding appointments and improving the did not attend rates at the practices.

Patients completed CQC comment cards to tell us what they thought about the practice, we received 24 completed cards. All of the comments we received were positive about the service patients experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection and three members of the PPG. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 the practice had a noise system operating in the corridors which prevented conversations in consulting rooms being overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located behind reception which meant calls could not be overheard by patients at the desk.

The reception desk was set back from the patient waiting area. Patients were encouraged to wait to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained; the practice also had music playing to reduce the risk of conversations being overheard.

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 and the business management team.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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, data from the national patient survey showed 89% said the GP involved them in care decisions and 95 % felt the nurse was good at explaining treatment and results. Both these results were in line with national averages.

Patients we spoke to 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us they were able to access translation services for patients who did not have English as a first language. The practice has a very low level of patients requiring translation service. Staff also told us they were able to access and use other tools such as Google translate.

The practice had developed care plans for older people and those identified as at risk such as those with LTC. We were told that changes in these patients were continually reviewed and the community support team involved as required. The clinicians were able to discuss any concerns with other clinicians outside of the clinical meetings at the formal coffee break held each day with clinicians.

We saw that families, children and young people were treated in an age-appropriate way and recognised as individuals.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the support provided by the practice and rated it well in this area. We saw that the practice sign posted patients to local support services such as Winterton winter programme. The patients we spoke to on the day of our inspection and the comment cards we received told us they were supported by the staff. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and patient website also told people how to access a number of support groups. There was information available for carers to ensure they understood the various avenues of support available to them. The practice held carers register and asked new patients registering with them if they were a named carer for anyone.

Staff told us that if families had suffered bereavement, they tried to follow these up particularly following end of life pathway.

The practice recognised isolation as a risk factor for older patients. There was information which promoted local groups. The practice were proactive in supporting older people, providing access to falls prevention and a consultant Geriatrician within the practice.

We saw that people suffering with long term conditions received regular annual reviews and if deemed appropriate they were reviewed more regularly. From the comments we received patients told us they felt supported and had access to services. The staff were aware of depression that may accompany these conditions and has service that could be accessed within the practice. Examples of these were the depression clinic.

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 people'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 Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice were also part of a local GP federation and were using the PGP tool kit to review and improve the service they delivered. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges. Examples of these are action to improve services following significant events. For example ECG s (electro cardio graphs) were to be booked to be undertaken in the surgery when the GP who requested them was present. This enabled the GP to review the results immediately; the practice had a policy which supported this.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG and patient information. We saw that they had developed actions and we looked the action plan for 2014 /15. Examples of these were increasing the use of online services to book appointments with GP s and the nurse practitioners. Other examples were engaging younger people and providing diabetic eye examinations at the branch surgery.

We saw in the waiting area a display for patients which detailed what patients had told and suggested to the practice and what they had done in response to this. This ensured that patients understood that the practice listened to them and were proactive in responding to issues raised. We saw a suggestion box in the reception areas and a separate notice board for the PPG. The practice produced a regular newsletter which provided a range of information to patients. Examples were friends and family test, 24 access to appointments, unplanned hospital admissions, text messaging, and staff vacancies.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

They recognised those with a learning disability, students, carers and the older population.

The practice had access to translation services and all staff were aware of how to access this.

The practice provided equality and diversity training through e-learning. The staff we spoke with were very aware of the importance of equality and diversity.

We saw that staff had regular meetings and felt supported in their role. We saw a range of different staff meetings for individual groups. Examples of these were dispensary, reception ,nurses and cleaners meeting. This ensured that staff had the opportunity to discuss work issues that concerned their individual role and receive regular practice business updates. .

The main practice building was situated in a two storey building with consulting on the ground floor. Patients with disabilities and patients with pushchairs were able to access all areas of the building. There was also a separate pharmacy attached to the building. The theatre suite was on the ground floor of the building which had been extended to accommodate the growing practice developments.

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. All areas of the practice were accessible to people with disabilities.

Access to the service

The practice opened from 08.30am to 6.30 Monday to Friday. Appointments with the GPs were available 9am to 12 noon and 2.00pm to 6.00 pm the practice closed for lunch between 1.00 pm to 2.00pm. The dispensary is open 9 am until 6.00 daily Monday to Friday with the same lunchtime closures.

The branch surgery at Burton Upon Stather is open for GP appointments between 9 .00 am to 1.00 pm and 3.00 pm to 5pm Monday to Friday except Tuesday when it is closed in the afternoon.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice offers two types of appointment routine and urgent. Routine appointments can be booked in advance. Appointments with the GP can be made up to 4 weeks in advance and up to six weeks in advance for the nurse and HCA. The practice also offers urgent on the day appointments for patients if they have an urgent medical appointment that can't wait until the next day. The practice does not use telephone triaging of patients we were told they have tried this in the past and found it not to be effective. However patients can book a telephone slot to receive and discuss test results. These appointments were introduced following the PPG patient survey results.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, 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. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care homes.

From the information we reviewed and the patients we spoke with we saw that patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. However during the inspection we observed one elderly lady asking for an appointment at reception and being asked to ring the practice the following day as all appointments had gone for the day.

We saw that older people and people with long-term conditions could access longer appointments or request a home visit if required.

Appointments were available outside of school hours for children and young people.

Patients were able to use online booking system and found it easy to use. The practice also offered text message reminder for appointments.

People whose circumstances may make them vulnerable were known to the practice. The practice worked in partnership with other organisations to understand the needs of the most vulnerable and provide flexible longer appointments for those that need them.

The practice were responsive to people experiencing poor mental health who's life style may be chaotic including the hard to reach groups. They were able to provide longer appointments and flexibility in booking appointments.

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 which was the practice manager. The practice had complaints forms that patients could complete, the complaints leaflets provided detailed information about the process.

We were told by staff that they would always try and resolve a complaint that was raised with them and if this was not possible direct them to the practice manager.

We saw that information was available to help patients understand the complaints system in the waiting area and online. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 15 complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way. We saw that the practice had an openness and transparency when dealing with the complaints. The complaints had been discussed with staff and the areas of concern raised by patients were systematically addressed in the response from the complaints manager. We saw that clinicians were involved in this process to ensure they were able to explain and address issues raised.

Minutes of practice and other staff meetings showed that complaints were discussed where appropriate with staff and action plans discussed. An example of this was following an incident when an action on a letter was missed and not acted upon. Staff now record on the letter what follow up action they have taken as a result of the clinicians initial instruction and ensure the clinician has

Good

Are services responsive to people's needs?

(for example, to feedback?)

initialled to note they have seen the letter. If the letter is not initialled it is returned to the clinician to ensure all actions have been taken as needed. When scanning onto the patient record the reception team ensure any action notes have been marked as complete by the reception team and the letter is initialled. If either is not the case then they are returned to the clinician for action.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found the vision and practice values were part of the practice's future plans.

The practice values, vision and goals were discussed with staff at their induction. We saw that as part of the productive general practice programme the practice were continually reviewing their processes to look at what could be done to improve care delivery and performance.

Staff told us that they had weekly meetings with their manager where their role in meeting these goals was discussed. Examples of the practice vision and values included improving the patient experience of the service they provided, improve productivity by reducing waste and inefficiency. The practice also wants to improve the work life balance for staff and release time to pursue clinical interests.

We spoke with 14 members of staff and they all knew and understood the vision and values and what their responsibilities were in relation to these. We saw evidence of good communication with staff however some staff told us they would prefer more regular updates.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We also saw that hard copies were also available. We looked at these policies and procedures and saw that processes were in place to ensure staff had read the policy. The practice staff were also encouraged to take part in doing a 'test your knowledge' quiz of some policies. All of the policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control, for safeguarding and learning disabilities. We spoke with14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing well and in line with national standards. We saw that QOF data was regularly discussed at team meetings and plans were produced to maintain or improve outcomes. We also saw that the practice regularly review their performance. Examples of these include reviewing all appointment data to understand if they met the needs of the practice.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we looked at two audits in detail and saw that repeat audit cycles had been completed and actions identified. An example was an audit of low back pain. We saw that following audit actions were developed, this resulted in following NICE guidance and ensuring all staff adheres to the guidance.

The practice had robust arrangements for identifying, recording and managing risks. The practice had a nominated person who monitored risk. The practice monitored and addressed a wide range of potential issues, such as the environment and infection control. We saw that the risks identified were discussed at the appropriate team meetings and updated in a timely way.

The practice held regular practice meetings and department meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were also departmental meetings. Examples of these were clinical, reception, dispensary and cleaning staff. All GP partners received a copy of the minutes of all meetings this ensured they were aware of developments and issues discussed. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment procedures, induction policy, and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys, PPG surveys, completed suggestion forms and complaints received. We looked at the results of the annual patient survey and 95% of patients agreed they were able to get through to the practice on the telephone. We also looked at the results for the friends and family test report for January 2015 and saw that at Winterton practice 98% would recommend the practice and at Burton upon Stather 90% would recommend the practice.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups; including older people and those with long term conditions. The PPG carried out surveys and met regularly. The PPG had a dedicated notice board and box to return completed PPG surveys in the reception area.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical and professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and we saw evidence to confirm this.

The practice currently has one GP registrars working in the practice. We saw that there were suitably qualified GP trainers available in the practice to support the registrars.

The practice had completed reviews of significant events and other incidents. We saw evidence that these were discussed at staff meetings to ensure the practice learned from and improved outcomes for patients. An example of this is when patients return blood pressure monitoring equipment the practice reception book the patient an appointment with the GP who requested the test to review the results.