High Green Medical Practice - Dr Z Khan

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 High Green Medical Practice on 29 September 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff understood their responsibilities to raise concerns and to report incidents and near misses. The practice had a formal system in place for the ongoing monitoring of significant events, incidents and accidents.
- Effective arrangements were in place to ensure that risks to patients and staff were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice had a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- The practice invested in staff development and training.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it difficult to contact the surgery by telephone especially when trying to make an appointment.
- 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 engaged with and supported by the management.
- The practice proactively sought feedback from staff and patients. Actions were taken as a result of feedback.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

There were areas of practice where the provider should make improvements:

- Consider how the telephone access for patients could be improved.

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:

- There was an effective system in place for reporting and recording significant events.
- Records of clinical and significant event meetings demonstrated that incidents were fully discussed. Records showed that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate.
- When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information and an apology. Patients were told about any actions to improve processes to prevent the same thing happening again.
- The provider regularly accessed the National Reporting and Learning System website to ensure safety alerts had been received.
- The practice had clearly defined and embedded systems and practices in place to keep patients safe and safeguarded from the risk of abuse.
- There was an appointed lead for health and safety and risks to patients and staff were assessed and identified actions completed. For example, the practice had completed risk assessments on the use of visual display units and assessed risks presented by having children's toys available in the waiting area. There was a recorded log of all risks and the health and safety lead arranged external annual reviews on their safety systems.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) for 2014/15 showed that the overall achievement of 78% of the available points was below the average when compared to the locality average of 92% and the national average of 95%. This performance had been improved in 2015/16 to an overall achievement level of 96%.
- The practice had similar to average exception rates. The practice overall clinical exception rate was 8.4%, compared to the local CCG average of 8.9% and the national average of 9.2%.

Summary of findings

(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.)

- Staff were aware of current evidence based guidance to deliver care and there was a system in place to check they were being followed.
- The practice had completed clinical audits and the outcomes were used to monitor quality and make improvements.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of staff appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the practice held meetings with the professionals involved in the care of patients receiving palliative care.
- Arrangements were in place to gain patients' informed consent to their care and treatment.
- Patients were supported to access services to promote them living healthier lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey results, published in July 2016, showed patients rated the practice similar to others for most aspects of care.
- Patients were treated with dignity and respect and they were involved in decisions about their care and treatment. Systems were in place to protect patient confidentiality.
- The practice held a carers' register and systems were in place, which identified patients who also acted as carers.
- Arrangements were in place to ensure that patients and carers received appropriate and effective support. Carers were provided with information on local services and offered annual health checks and flu vaccinations.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Urgent appointments were available on the same day.

Summary of findings

- The provider was aware of the low patient satisfaction scores for telephone access. Solutions being explored included a system to prioritise calls at the busiest times of the day.
- The practice offered extended hours and telephone appointments to working patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. The practice had responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

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

- The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were aware of the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by the management and spoke of a strong learning culture.
- The practice had a comprehensive set of policies and procedures to govern activity and held regular governance meetings.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions to ensure that patients and staff were protected from the risk of harm. This included for example, arrangements for the safe management of medicines.
- 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 proactively sought feedback from staff and patients, which it acted on. There was an established virtual patient participation group and the practice carried out their own annual patient survey.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The practice offered personalised care to meet the needs of the older people in its population.
- Flexible appointments were available for older patients.
- All patients aged 65 and over were offered a health check including blood tests.
- Patients aged over 75 had been advised on their named, accountable GP.
- The practice engaged with community teams involved in care of the elderly population.
- A dedicated telephone line was provided to local care and nursing homes and the GP carried out regular ward rounds.

People with long term conditions

Good

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

- The practice nurse and advanced care practitioner provided home visits for chronic disease management.
- Patients at increased risk of hospital admission were identified as a priority and had written care plans in place.
- The practice Quality and Outcomes Framework (QOF) for the care of patients with long-term conditions was worse than the local and national average. The most recent published data was for 2014/15 and the practice showed us unpublished data that showed an improvement in the QOF performance that brought the practice into line with local and national averages.
- Longer appointments were available when needed and home visits made to patients who were housebound.
- The GPs and nursing team worked with relevant healthcare professionals to deliver a multidisciplinary package of care to patients with complex needs.
- The practice had an effective call and recall system that was supported by a text reminder service.

Families, children and young people

Good

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who did not attend hospital appointments.
- Immunisation uptake rates for standard childhood immunisations were better than the local CCG and the national averages. For example, childhood immunisation rates for the vaccination of children aged two to five and up to five years of age were consistently between 97% and 99%.
- Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice's uptake for the cervical screening programme was 87%, which was better than the national average of 82%.
- Extended opening provided early morning and late evening appointments five days a week.

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 offered extended opening hours each week day.
- The appointment telephone line was accessible to patients who worked during the day.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- Extended opening provided early morning appointments and late evening appointments each week day.

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 35 patients with a learning disability and annual health checks had been carried out on all of these patients.

Summary of findings

- The practice had a high prevalence of young patients living in vulnerable circumstances, when identified the practice assisted and supported these patients on an individual basis and the provider had an appointed vulnerable patient lead.
- Staff had been trained 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.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.
- Patients whose first language was not English were offered a translation service via telephone or with an interpreter present to support consultations. The provider had a policy to provide translators to protect potentially vulnerable family members from using relatives as interpreters.
- The practice signposted patient to local self-help groups, for example; alcohol and substance misuse services.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia.
- The practice held a register of patients who experienced poor mental health. Clinical data for the year 2016/17 showed that 16 of 25 patients on the practice register who experienced poor mental health had a comprehensive agreed care plan. The provider had planned to complete the remaining nine care plans before April 2017.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example, the community mental health team.
- The practice maintained a register of patients diagnosed with dementia. The percentage of patients diagnosed with dementia, whose care had been reviewed in a face to face review in the preceding 12 months was 77%, which was comparable with the national average of 84%.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was generally performing below local and national averages. A total of 366 surveys (3.6% of the patient list) were sent out and 65 (18%) responses were received, which is equivalent to 0.7% of the patient list. For example:

- 32% of the patients who responded said they found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 72% and a national average of 73%.
- 75% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 84%, national average 85%).
- 73% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 85%, national average 85%).
- 66% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who had just moved to the local area (CCG average 77%, national average 78%).
- 79% of the patients who responded said they found the receptionists at this practice helpful (CCG average 88%, national average 87%)

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received six comment cards. Patients said the practice they received an excellent service and that all staff listened, were helpful and respectful. Three patients commented that they had experienced difficulties when trying to contact the surgery by telephone to make an appointment although these respondents had positive comments on the care received. We spoke with five patients on the day of our inspection. They told us that they were satisfied with the care provided by the practice. They said they were always treated as an individual, respected, but had experienced difficulties contacting the practice in the morning to get an appointment. The provider had a virtual patient reference group (PRG). PRGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The virtual group had been in existence for five years and consisted of approximately 900 members. The practice had encouraged patients to attend the practice and give their views by the organisation of a coffee and cake afternoon. The most recent meeting had taken place in March 2015 and resulted in three action points which were published in the waiting area. For example, one action point was to monitor the telephone access. The provider had monitored the volume of calls and the results had trialled a message system aimed at prioritising calls at the busiest times of the day.

The practice monitored the results of the friends and family test monthly. The results over a six month period (February 2016 to August 2016) showed that of the 437 responses received 252 were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and 79 patients were likely to recommend the practice. The remaining results showed that ten patients were neither likely nor unlikely to recommend the practice, 24 patients were unlikely to recommend the practice, 62 patients stated they were extremely unlikely to recommend the practice and ten said they did not know. The comments made by patients in their responses were overall positive and aligned with the comments and responses received from comment cards, the patients spoken with and the GP survey results. The negative comments highlighted that patients experienced difficulties when contacting the practice by telephone.

Areas for improvement

Action the service SHOULD take to improve

- Consider how the telephone access for patients could be improved.

High Green Medical Practice - Dr Z Khan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and an expert by experience.

Background to High Green Medical Practice - Dr Z Khan

High Green Medical Practice is registered with the Care Quality Commission (CQC) as a single handed GP. The GP has a practice manager/business partner. The practice is located in Nottingham. The practice has good transport links for patients travelling by public transport and parking facilities are available for patients travelling by car. The practice is situated within a joint healthcare facility that houses three GP practices, City Care Homes (an adult support service run by the City Council), phlebotomy and dietary services. The practice is situated on the ground floor of the building and has dedicated rooms that include seven consulting rooms. The building aims to provide a one stop shop for patients. The second floor has treatment rooms for services such as phlebotomy, dental treatment and physiotherapy that the provider could refer patients to. The community team are sited on the third level of the building. There is level access to the building, doors to the building are automated and lifts provide access to each floor. All areas within the practice are accessible by patients who use a wheelchair or parents with a pushchair.

The practice team consists of two partners, one male GP and one female practice manager partner. The partners are supported by two salaried GPS and five regular longstanding locum GPs. The GPs work a combined number of sessions of 48 per week (equal to six whole time equivalent GPs). The clinical team includes a lead practice nurse, an advanced care practitioner and a practice nurse. Clinical staff are supported by an assistant practice manager, two medical secretaries, a reception manager, a senior practice administrator and four administration/ reception staff. In addition to the partners, there are a total of 14 staff employed either full or part time hours to meet the needs of patients. The practice is accredited to train GPs and has two whole time equivalent training doctors in post.

The practice is open between 8am and 7pm on a Monday, Wednesday and Friday and between 8am and 8pm on a Tuesday and Thursday. Appointments are available throughout the day through a rolling rota so appointments could be made each week day from 8.30am 6.50pm when closing at 7pm and 7.50pm when closing at 8pm. Extended hours are offered at the practice each week day evening. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service, provided by (Nottingham Emergency Medical Services (NEMS), via the NHS 111 service. The nearest hospital with an A&E unit and a walk in service is Queen's Medical, Nottingham The nearest walk in centre was the urgent care centre in Nottingham city centre.

The practice has a Personal Medical Services contract with NHS England to provide medical services to approximately 9,400 patients. It provides Direct Enhanced Services (DES),

such as the childhood immunisations, extended hours and asthma and diabetic reviews. The Local Enhanced Services (LES) offered included support to care home and care plans for vulnerable adults.

The practice has a high proportion of patients from ethnic minorities, 24.9% are White British compared to the England average of 17.1%. The largest ethnic minorities are South Asian (47.6% of the practice population) and Eastern European (15% of the practice population). The income deprivation affecting children of 33% was higher than the national average of 20%. The level of income deprivation affecting older people of 43% was higher than the national average (16%). The age demographic for the practice patients shows a relatively young group of patients. For example, 29% of patients are under the age of 18 (national average 21%) and 4% of patients are aged 65 and over (national average 17%). The patient group is transient and this migration on people has seen the number of patients joined and those that have left in a 12 month period give a turnover of that has ranged between 12% and 22% in recent years.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 29 September 2016.

During our visit we:

- Spoke with a range of staff including the partners, GPs, nurses, assistant practice manager, administration staff and we spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed 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 were provided for specific groups of people and what good care looked 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)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a computerised system was in place for reporting and recording significant events. Staff told us they would inform the deputy practice manager and or the partners of any incidents to ensure appropriate action was taken. The practice manager and the lead practice nurse were responsible for disseminating safety alerts and there were systems in place to ensure they were acted on. Alerts were screened and when appropriate, logged and forwarded to the appropriate practice staff. Alerts were a standing agenda item at the clinical meetings. Non-clinical alerts were disseminated manually and a hard copy of the alert signed by administration staff. The practice manager was able to give an example of a drug alert for a hormone to control glucose levels in the blood, issued on 6th September. The practice manager had actioned the alert appropriately, a search had been run and no action was required. Alerts were shared with the wider practice team at practice meetings held monthly or at the clinical meetings held weekly. The practice manager accessed the National Reporting and Learning Service (NRLS) to cross check with their own records to ensure that no alerts had been missed.

We found that significant event records were maintained and systems put in place prevented further occurrence. Significant event records were clearly documented at the time they were reported. Action points recorded on the significant event forms were used to inform staff of the event as a standing agenda item at practice meetings. Documentation available demonstrated that any lessons learnt and action taken had been shared with staff and remedial action had been taken. Ongoing monitoring was demonstrated by minutes of meetings where actions taken were reviewed. Staff completed an incident recording form which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Records we looked at showed that 12 significant events, both clinical and operational had occurred since April 2016. One of the events related to pharmacies authorising repeat prescriptions requests without authorisation from the practice. One patient had not been given a repeat medicine by the provider due to an overdue medication review; the pharmacist issued the prescription and asked the patients to present a prescription at the practice retrospectively. The patient presented at the practice with the medication. The GP involved raised as a significant event The practice spoke with the pharmacist and advised that this should not have happened and ongoing monitoring would be done to identify any further incidents. The incident was raised with the medicines management team from the local clinical commissioning group (CCG).

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements and policies were available to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP partner was the safeguarding lead for adults and children. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. The GP partners and nurses were trained to safeguarding level three and the non-clinical staff were trained to safeguarding level one. The GPs told us that they provided reports where necessary for other agencies. The practice held registers for children at risk, and children with protection plans were identified on their individual computerised records. The practice had close links with the safeguarding team, health visitors and hospitals and followed up by telephone those who did not attend for childhood vaccinations and immunisations. The practice had safeguarding as a standing agenda item for clinical meetings and discussed any concerns about children with a named health visitor and other relevant professionals. The practice gave an example about a significant event recorded after a patient passed away in a care home after which court proceedings were brought against the home. The practice was found to have done no wrong but produced a report as a reflective learning exercise and reviewed with a member of the safeguarding team. A learning outcome was to increase awareness through the introduction of a forum for all GP providers to discuss nursing homes.

Good

Are services safe?

A notice was displayed in the waiting room, on the reception desk, in treatment rooms and in consultation rooms advising patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. (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). Clinical staff normally acted as chaperones but reception staff undertook this role when required. Staff clearly described their role, for example, staff knew where to stand when acting as a chaperone. A chaperone policy was available to support staff. The policy made appropriate reference to recording on the patient records that a chaperone was present and summarised the role of a chaperone.

The practice was situated in a service managed building maintained by Community Health Partnerships (CHP), part of NHS Properties. We observed the premises to be clean and tidy and appropriate standards of cleanliness and hygiene were kept. There were cleaning schedules in place and cleaning records and standards were reviewed and problems reported to the cleaning supervisor. The practice nurse was the clinical lead for infection control and received update training quarterly from the infection control leads and accessed the policies from an online portal provided by Nottingham City Care. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The last one in July 2016 had not identified any action required. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place through the landlord of the property. The landlord was responsible for the disposal of the sharps bins and a protocol for needlestick injuries was in place. All boxes were seen to have been signed and dated with an assembly date and general waste bins had foot operated closure. The property maintenance services were managed by the landlord and this included the cleaning. We were told that the cleaning contractor was responsible for emptying the clinical waste bins. Clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs. Immunisation was offered to all staff for hepatitis B and flu jab. The practice carried out annual audits on hand hygiene (glow and tell) and fridge cleaning audits were carried out every six months.

There were fully effective arrangements for managing medicines in the practice. Medicine prescribing practices we reviewed showed that systems in place for patients to receive a formal review of their medicines were effective.

- There were effective processes for managing repeat prescriptions for high risk medicines that required monitoring. Monthly audits were carried out for all patients on high risk medicines. Unless it compromised patient safety, the practice had a policy to not issue a repeat prescription for medicine until the test results were available. Patients seen to be non-compliant with their medication issued were followed up.
- The practice had an effective process for making changes to prescribed medicines in patient's records following a visit to hospital. The process worked with allocated daily roles assigned to GPs who added and removed patient repeat medication items following their discharge from hospital.
- Formal arrangements for the review of patient medicines were in place. For example patients on four or more medications were invited to be reviewed in a GP consultation every six months.

We found that blank computer forms and prescription pads were securely stored and their use monitored. The practice had systems for ensuring that medicines were stored in line with manufacturers guidance and legislative requirements. This included daily checks to ensure medicines such as vaccines were kept within a temperature range that ensured they were effective for use. Specific medicine directions (Patient Group Directions for the practice nurses) were adopted by the practice to allow the practice nurses to administer specific medicines in line with legislation.

We reviewed the staff files for two staff employed at the practice, a nurse and a locum GP. We found that all appropriate recruitment checks which had been undertaken prior to employment. For example, proof of identification, references, qualifications, health checks, registration with the appropriate professional body and the appropriate checks through the DBS. Records showed that

all permanent staff had criminal records checks carried out through the DBS. The practice directly employed locum GPs. Locum records we saw evidenced that a check was carried out to confirm the locum was registered to practice with their professional body, the General Medical Council (GMC) and information was held on employment history, qualifications, references and appropriate checks through the Disclosure and barring Service to confirm the suitability of the GP to work with patients. Locums were supported with access to online learning, and given allocated time to support the practice with other clinical duties. For example, four hour sessions were booked and two and half hours were allocated to face to face appointments.

Monitoring risks to patients

The landlord of the property was responsible for the maintenance and management of the premises. The practice had procedures in place for monitoring and managing risks to patient and staff safety. Minutes of practice meetings showed that health and safety was discussed when required. The practice had a health and safety policy available and the mandatory poster was displayed in the reception area. The poster identified the named health and safety lead at the practice. This person had not received additional training specific to this role but used an outside expert to undertake annual audits and complete and review risk assessments. We saw that there was a comprehensive, completed list of risk assessments relating to the premises, patients, visitors and staff working at the practice. For example, risk assessments for mobile workers, lifting equipment, display screen equipment and children's play equipment. Records were available to demonstrate that a number of other risk assessments had been completed by the property landlord to monitor the safety of the premises. These included fire risk assessments, checking of fire alarms, emergency lighting and infection control. Control of Substances Hazardous to Health (COSHH) was managed by the practice and safety data sheets for each product were kept where the practice could access them. The practice evidenced that the landlord had carried a legionella risk assessment and ongoing checks were carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

All electrical and medical equipment was checked annually to ensure the equipment was safe to use and working properly. Records showed equipment was maintained and calibrated in September 2016 and electrical safety checks had last been carried out in September 2016.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. The practice used GP locums to support the clinicians and meet the needs of patients at the practice at times of absence. There was a policy that holidays were coordinated to ensure that no more than two members of staff had annual leave at the same time.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. There was an instant messaging system on the computers in all rooms. An emergency panic button in the reception, consultation rooms and treatment rooms alerted staff to any emergency. The landlords employed security staff who manned the building during opening hours. There was a practice policy to have no fewer than two staff in the building at any given time. The practice had a first aid box and accident forms that were specific to the nature of the incident. For example, there was a form for reporting incidents that related to the building as a whole and a separate internal accident/incident/hazard reporting form. Staff training records showed that all staff had received recent update training in basic life support and staff spoken with confirmed this. The practice had a shared defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) on the premises, shared between the three practices located in the building. There was oxygen with adult and children's masks. The equipment was shared and the practice had systems in place to ensure emergency equipment and medicines were regularly checked. 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.

Good

Are services safe?

The practice had undertaken a fire evacuation drill in the preceding 12 months (21st April, 2016). There was a fire warden who attended meetings with other staff in the building to review the fire evacuation drills.

The practice had a comprehensive business continuity plan in place for responding to emergencies such as loss of premises, power failure or loss of access to medical records. The plan included emergency contact numbers and arrangements to operate from neighbouring practices in addition to information for staff of mitigating actions to reduce and manage the identified risks. There were hard copies kept off site and electronic copies could be viewed in the practice or remotely.

Good

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 GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The provider told us that they planned to appoint a NICE lead when salaried GPs returned from maternity leave and would reintroduce it as a standing agenda item at clinical meetings. In the interim, GP Registrars were tasked with presenting new NICE guidelines at the clinical meetings and new policies were implemented when required and disseminated via email.

Management, monitoring and improving outcomes for people

The practice collected information for the Quality and Outcomes Framework (QOF) to measure its 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 for 2014/15 showed that it had achieved 78% of the total number of points available. The practice QOF results were lower than the local Clinical Commissioning Group (CCG) average of 92% and the national average of 95%. The practice overall clinical exception rate of 8.4% was higher than the local CCG average of 8.9% and lower than the national average of 9.2%. (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.) Further practice QOF data from 2014/15 showed:

- Performance for the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was within target (140/80 mmHg or less) was below the local and national average (60% compared to the local average of 74% and national average of 78%). The practice exception reporting rate of 11.4% was higher than the local CCG average of 7.7% and the national rate of 8.7%. The practice had carried out an audit in 2016 of patients on the diabetic register who were not achieving target levels for managing their condition. The results highlighted that there was a trend of not attending for reviews among some of the ethnic minority patients. The practice had written to each patient and planned to telephone those who had not attended by a set date.
- Performance for the percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken the preceding 12 months was 82% which was below the local CCG average of 89% and national average of 90%. COPD is the name for a collection of lung diseases. The practice exception reporting rate of 17% was higher than the local average exception rate of 9.4% and national average of 11.1%.
- Performance for mental health related indicators was lower than the local CCG and national averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 33% compared to the local CCG average of 83% and England average of 88%. The practice had eight excepted of the 109 patients for this clinical area, equivalent to 7.3% (the local CCG average exception rate was 11.2% and England average was 12.6%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in

a face-to-face review in the preceding 12 months was below the local CCG and national average (77% compared to the local CCG average and England average of 84%). The practice clinical exception rate of 1.9% for this clinical area was lower than the local CCG average of 8.5% and the England average of 8.3%. This represented one patient.

Information received at this inspection demonstrated that the practice had improved the QOF performance and achieved 96% of total QOF points available in 2015/16. We saw that coding was an issue. For example, newly diagnosed diabetic patients should be referred to a 'JUGGLE' service to advise and support about lifestyle and how to mange the condition. This was seen to have been done but not coded in two patients that we reviewed.

The practice had implemented a text reminder service for patients with long term conditions to remind the patients that their review was due. The reviews had been added to prescriptions and a recently implemented electronic

prescription service (EPS) had improved patient recall (pharmacists have a legal duty to inform the patient that there review is due). Flu clinics were being used to catch up on reviews due. A member of the reception team was being trained to be a healthcare assistant to conduct reviews for patients with long term conditions. The practice demographic was atypical, the population was transient and exception reporting was not used extensively due to the senior GP ethos. The provider planned to improve the prevalences (the percentage of the population affected with a long-term condition) and had found that clinical coding was not always inputted by GP locums. This resulted in the practice not being rewarded for patient care that had been carried out.

The practice had identified patients at higher risk of hospital admission and had introduced appropriate care plans where required for the ongoing management of these patients. These care plans were reviewed at monthly multi-disciplinary team meetings, opportunistically when patients attended or at least once every six months. Action plans were developed with other healthcare professionals when areas of patients' care needed to be reviewed. Evidence was available to show that the practice had systems in place to follow up patients that had not attended reviews of their condition either at the practice or at the hospital. Special notes were documented and shared with other healthcare professionals. For example, the out of hours service was advised of any patient with suspected opiate (medicines containing opium or its derivatives) abuse.

Clinical audits carried out demonstrated quality improvements to care, treatment and patients' outcomes. We saw that ten clinical audits had been completed in the last year; these were a mix of single phase and cyclical audits both clinical and administrative. One of the audits looked at the low uptake of screening for bowel cancer. This audit had been initiated at the practice and had been adopted by other practices in Nottingham with low uptake rates. Monthly lists of patients not attending their appointment for bowel screening were followed up by a telephone call and a second testing kit requested. The outcome of the audit was a cross culture issue with some ethnic minorities where for example some ethnic groups had their screening done when travelling back annually to their country of origin. There was audits of consent records performed twice in the preceding 12 months, the second cycle completed in June 2015 showed that consent had been 100%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff had access to and made use of e-learning training modules and external and in-house face-to-face training.

The practice had developed an effective appraisal system which included detailed appraisal documents. Staff had received a recent appraisal and records detailed development plans for all staff. The GPs and practice nurses had all completed clinical specific training updates to support annual appraisals and had personal development plans to support revalidation. The practice nurses received training and had attended regular updates for the care of patients with long-term conditions and administering vaccinations. Administration staff had received team appraisals and six monthly personal review meetings. This system had been developed with input from the practice team.

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 shared computer drive. The provider was able to demonstrate that staff were aware of their responsibilities for processing, recording and acting on any information received. The practice tracked referrals such as urgent scan requests.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services. For example, when referring patients to secondary care such as hospital or to the out of hours service. Information was shared with the out of hours service so they were aware of the patient's wishes and treatment choices when the practice was closed. There was a system of special patient notes done online through the 'Adastra' system. The practice completed a daily check on patients who attended the out of hours service. Records showed

that there had been no concerns identified and the senior GP was a board member of the out of hours provider, Nottingham Emergency Medical Services (NEMS). Staff told us that they could discuss any concerns about children and families with a named health visitor. Multi-disciplinary team meetings were used to discuss patients on the practice palliative care register. Detailed minutes of the meetings were maintained and care plans were routinely reviewed and updated following the meetings. The practice used the gold standards framework for palliative care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We found that staff understood and had an awareness of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records. Audits were carried out to check that consent was obtained.

Supporting patients to live healthier lives

The practice had identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing.

- 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 and alcohol cessation.
- Patients were signposted to relevant health promotion services for example, smoking cessation and alcohol clinics were provided in the same building by Nottingham City Care.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40-74 years and patients aged 75 years. This service was provided by one of the practice nurses with support from a GP when required.

The practice had a comprehensive screening programme. A full range of travel vaccines, childhood immunisations and influenza vaccinations were offered in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for all childhood immunisations was better than the local CCG average. For example, childhood immunisation rates for the vaccination of five year olds ranged from 97% to 99% of eligible patients.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 QOF year was 97%, which was better than the England average of 81%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the number of females aged 50-70 years, screened for breast cancer in last 36 months was low 52% compared to the average across England of 72%. Data for other cancer screening indicators such as bowel cancer were below local and national averages.

We saw that health promotion information was displayed in the waiting area and also made available and accessible to patients on the practice website. The nurses carried out health screening checks on all new patients registering at the practice. The practice focussed on children under six years of age to ensure that immunisation records were up to date or brought up to date and with female patients to ensure cervical screening was up to date. The practice were looking to extend this to other vulnerable groups. The practice explained this system helped achieve the high uptake rates for childhood vaccinations and immunisations and cytology.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them 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; conversations taking place in these rooms could not be overheard.
- The area around the reception desk was open. To promote confidentiality telephone calls could be responded to away from the front desk to support the privacy of patients when speaking to reception staff at the desk. If patients wanted to discuss something privately or appeared distressed a private area was available where they could not be overheard.

We spoke with five patients during the inspection and collected six Care Quality Commission comment cards completed by patients to tell us what they thought about the practice. Patients were positive about the service they received. Patients said that they received good care from all staff, the GPs were caring and staff were polite, considerate and helpful.

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was similar to local and national practice averages for satisfaction scores on consultations with GPs. For example:

- 83% of the patients who responded said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 87% and national average of 89%.
- 83% of the patients who responded said the GP gave them enough time (CCG average 86%, national average 87%).
- 94% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%).
- 85% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).

The practice was similar to the average satisfaction scores on consultations with the nurse. For example:

- 94% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 91%).
- 88% of the patients who responded said the last nurse they saw or spoke to was good at listening to them (CCG average 91%, national average 91%).
- 93% of the patients who responded said the last nurse they saw or spoke to was good at giving them enough time (CCG average 93%, national average 92%).

The patient satisfaction with reception staff was below local CCG and national average. Data showed that:

- 79% of the patients who responded said they found the receptionists at the practice helpful (CCG average 88%, national average 87%).

The practice were aware of the results and said that issues had been addressed with the reception team. Recently gathered positive feedback suggested improvements had been made. For example, through the friends and family test, out of 21 responses from the survey started in June 2016, 94% of respondents said they found the receptionists very helpful or fairly helpful.

Care planning and involvement in decisions about care and treatment

Patients told us 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.

Results from the national GP patient survey published in July 2016 showed patients response to their involvement in care planning with a GP or nurse was comparable with local and national averages. For example:

- 84% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 80% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 82%, national average 82%).
- 86% of the patients who responded said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average 90%, national average 90%).

Good

Are services caring?

- 94% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 86%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

The practice had a carers' policy in place, which staff were aware of. Written information was available for carers to ensure they understood the support available to them. This included notices in the patient waiting room which told patients how to access a number of support groups and organisations. Carers were provided an information booklet that detailed emergency procedures such as how to recognise and respond to a stroke or heart attack as well as information on home security and fire safety. There were 153 carers on the practice carers' register, which represented 1.6% of the practice population. The practice's computer system alerted the GPs and nurse if a patient was also a carer and patients were offered a flu vaccination and health checks. There was a recall system in place for carers to be invited for their flu vaccination and health check.

Staff told us that if families had suffered bereavement, patients were offered an appointment with a clinician to offer to the family. A card was normally sent out to the family offering an appointment with a convenient time with the GP. Leaflets and other written information on bereavement was available for patients in the waiting area and on the practice website. Families and carers were signposted to support services such as 'CRUSE' a local service that offered bereavement counselling. Staff were made aware of any death through a notification board and the practice told us that any death was discussed at the next clinical meeting as a standing agenda item. The practice had a high percentage of patients who were Muslim. The GP explained to Muslim families the barriers to fulfil requests for an early burial and handed out a burial directory specifically for the Muslim population that explained procedures after death.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- Patients with a learning disability were offered longer appointments (between 30 minutes and one hour) at a time which was suitable to them and their carer.
- With administration support, the nurses followed up all patients on the admission avoidance register following their discharge from hospital and discussed at the weekly clinical meetings
- The practice had access to appointments for patients who worked. We found that patients were offered online access to book appointments, request repeat prescriptions, access test results and view a summary care record.
- Facilities for patients with mobility difficulties included a ramp for ease of access to the entrance of the practice. The front doors to the practice were automatic and patients with poor mobility. Adapted toilet facilities were available for patients with a physical disability.
- The practice referred patients experiencing memory loss to the local community memory loss clinic.
- Access was available to translation and interpretation services to ensure patients were involved in decisions about their care. The practice website was available in a number of languages and text messaging using google translate was used. Seven languages were spoken between the practice staff including Urdu, Punjabi and Polish.
- The provider had a policy to provide translators to protect potentially vulnerable family members from using relatives as interpreters.
- Baby changing and breast feeding facilities were available.
- There were longer appointments available for older people and patients with long-term conditions.
- The practice made patients aware that home visits were available for patients who were unable to attend the practice.
- Staff told us that there was an unwritten policy to offer same day appointments for children aged under five as well as patients assessed as requiring an urgent appointment.
- The practice had been proactively engaged with the local community by engagement with health promotion discussions on local radio stations.
- One of the GPs attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed. For example, the practice was part of the Nottingham City GP Alliance (NCGPA) a federation within a group of practices known as the Robin Hood cluster. The practice was represented at federation meetings and cluster board meetings. Recent discussions included plans for a local enhanced service to provide translation service to allow extra GP time for patients and improve the literature available in foreign languages.

Access to the service

The practice was open every week day between 8am and 7pm on a Monday, Wednesday and Friday and between 8am and 8pm on a Tuesday and Thursday. Appointments were available throughout the day through a rolling rota so appointments could be made each week day from 8.30am 6.50pm when closing at 7pm and 7.50pm when closing at 8pm. Extended hours were offered at the practice each week day evening. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service, provided by (Nottingham Emergency Medical Services (NEMS), via the NHS 111 service. The nearest hospital with an A&E unit and a walk in service was Queen's Medical, Nottingham The nearest walk in centre was the urgent care centre in Nottingham city centre.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages for opening hours.

- 68% of patients were satisfied with the practice's opening hours which was below the CCG average of 78% and national average of 76%.
- 32% patients said they could get through easily to the surgery by phone (CCG average 72%, national average 73%).

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice said they monitored the number of telephone calls on a monthly basis and that solutions being explored included a new telephone system. The practice monitored the number of calls and the nature of requests and told us that audits evidenced that appointment capacity was not a problem although the practice had identified a problem with patients requesting a specific GP. The practice offered approximately 45 GP sessions per week on average and in addition had six (Advanced Care Practitioner) ACP sessions per week (sessions were between 16 and 18 appointments each). Call duration had been analysed and language problems had been identified as a problem.

The practice had a system in place to assess whether a home visit was clinically necessary. The named GP had the responsibility for coordinating the patients care and made the decision on the urgency of the patients need for care and treatment and the most suitable place for this to be received. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Non-clinical staff would refer any calls which caused concern or they were unsure of to a clinician for advice. Information in the patient leaflet and on the practice website informed patients to contact the practice if they required a home visit. Further information informed patients that home visits would be made to patients who were housebound only.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints at the practice. We saw correspondence for 18 complaints (written and verbal) received over the past 12 months and found that all had been responded to, satisfactorily handled and dealt with in a timely way. The written response letter from the practice did not include details of who to contact if not happy but the practice told us that a complaints leaflet was sent out with each response. This leaflet included the contact details for the ombudsman.

Records showed that complaints were discussed at practice meetings. We saw that lessons were learnt from concerns and complaints and action was taken to improve the service. For example, the practice had received a complaint from a patient unhappy about the care following gender reassignment. In response, the practice arranged equality and diversity training for all staff.

We saw that information available to help patients understand the complaints system included leaflets available in the reception area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

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 written set of aims that set out a non-hierarchical approach to providing treatment and to create a motivated and skilled workforce through training, support, supervision and guidance. Staff we spoke with were aware of the values and said they felt involved in the future plans for the practice. The practice produced a business plan that was reviewed annually. The four key areas were premises, staffing, finances and any other interests. The management demonstrated awareness and a strategy to address future challenges. For example, there was a succession plan in place and a strategy to manage the income reduction that resulted from a change of contract of the services provided.

Governance arrangements

Governance arrangements within the practice were comprehensive and inclusive. We saw examples of risks that had been well managed:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities and all staff were supported to address their professional development needs.
- Practice specific policies and procedures were implemented and were available to all staff. An internal shared computer folder was used to advise staff when key policies were updated or of any new policies.
- We found that systems were supported by a strong management structure and clear leadership.
- Clinical and internal audits were carried out and the outcomes used to monitor quality and make improvements.
- Arrangements for identifying, recording and managing risks and implementing mitigating actions were in in place to ensure that patients and staff were protected from the risk of harm. These included the arrangements for the safe management of medicines.

Leadership and culture

The GPs and practice manager partner were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately.

The provider was aware of and complied with the requirements of the Duty of Candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. When there was unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

Staff told us that regular practice meetings which involved all staff were held and staff felt confident to raise any issues or concerns at these meetings. Topics on the agenda included significant events, complaints, safeguarding, health and safety and other governance arrangements. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this and how they would be protected and this was confirmed in discussions we held with staff.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. The practice had tried to set up a patient participation group (PPG) but they told us that there was no interest from patients in attending meetings at the practice. The provider decided to establish a virtual patient reference group (PRG), established for approximately five years, that now included approximately 900 members. The provider promoted the group through posters and leaflets and communicated via email. The practice had encouraged patients to attend the practice and give their views by the organisation of a coffee and cake afternoon. The last meeting held in March 2015 and had resulted in three action points; to monitor the telephone access, to increase patient awareness of the extended opening times and to give consideration to weekend opening. The practice had monitored the telephone access, found the problem to be a high volume of calls during the first hour of opening and implemented

Are services well-led?

Good

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

an automated answering system that invited patients to call back later if the call was not for an urgent matter. The opening hours had been promoted through an increased presence on social media. The practice was seen to be active on Facebook and Twitter in addition to having its own website. Weekend opening had been considered but was on hold until two doctors returned from maternity leave.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice had completed reviews of significant events and other incidents and had ensured that lessons learned from these were used to make improvements and prevent further reoccurrence. The practice was a training practice and had plans to continue this after succession planning had taken place. A number of staff we spoke with complimented the partners on providing an excellent learning environment that provided both financial support and an investment of time from the partners to develop individuals.