Eden Surgery

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Eden Surgery on 26 January 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well led services. It was rated good for providing effective, caring and responsive services. All the population groups inspected were rated requires improvement overall.

Our key findings were as follows:

- Systems were generally in place to keep patients safe and to protect them from harm. However, robust procedures were not followed in respect of staff recruitment, the management of controlled medicines and infection control.
- Improvements were required to the operation of systems designed to regularly assess and monitor the quality of service provision.
- Most staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- There was a clear leadership structure and staff felt supported by management. However, the practice had not proactively sought feedback from staff and as a result some were not fully aware of the practice vision and values.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Most patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- Performance management data showed patient outcomes were good and mostly above average for the locality.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG).
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure robust systems are in place for assessing and monitoring the quality of services provided. This includes arrangements for infection control, medicines management, staff training and development.
- Ensure documentary evidence of appropriate recruitment checks on staff is maintained.

In addition the provider should:

- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Ensure that staff are aware and identify with the practice vision and values.
- Ensure a register for all equipment used in the practice is kept for auditing purposes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

Staff understood their responsibilities to raise concerns, to report incidents and near misses. There were enough staff to keep patients safe. Appropriate measures were in place to check the safety and suitability of premises and equipment. When things went wrong, lessons were learned and communicated to relevant staff to support improvement.

Although risks to patients were assessed, the systems and processes to address these risks were not always robust to ensure patients were kept safe. Areas of concern where the practice must make improvements relate to recruitment, cleanliness and infection control and medicine management.

Records relating to the management of the service for example safety alerts and the practice's procedures for dealing with emergencies required updating and sharing with staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it to assess patients' needs and plan their care. This included assessing patients' mental capacity where appropriate and obtaining appropriate consent.

Health promotion and prevention was routinely and opportunistically offered to reduce risks to patient's health. Nationally reported data showed positive patient outcomes were achieved and rated at / or above average for the locality.

Staff worked with other multidisciplinary professionals to ensure appropriate health and social care support was available to patients and that appropriate information was shared. Most staff had received training appropriate to their roles and there was evidence of appraisals and personal development plans being undertaken.

We found limited evidence that clinical audit was driving improvement in performance to improve patient outcomes and this is an area the practice should make improvements in.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Patients we spoke with told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. This was reflected in the national GP patient survey results published in January 2015. The results showed most patients rated the practice higher than others for several aspects of care including: nurses and GPs listening to them, giving them enough time and explaining tests and treatments. We saw evidence of care planning arrangements and patient involvement in agreeing these.

We observed staff speaking with patients in a helpful and polite manner whilst maintaining confidentiality. Staff helped patients and their carers to cope emotionally with their care and treatment. This included providing information on support groups for different long term conditions, mental health needs, counselling and bereavement.

Patients had access to a citizen's advice bureau advisor who worked closely with the practice. A weekly surgery was held on Wednesdays between 9:30am and 1:00pm to provide various support and advice to patients, including financial matters.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. This included participating in the CCG led Erewash Hub services which comprised of local GPs providing appointments from 4:00pm to 8:00pm daily and 9:00am to 2:00pm at weekends from the local community hospital.

Most patients we spoke with and comment cards received showed people found it easy to make an appointment with urgent appointments available the same day. A few patients said obtaining non urgent appointments was sometimes difficult and this was to be reviewed by the practice.

We found access to appointments and services took account of the different people's needs to promote equality. These included home visits for older people, extended hours in the morning for working age patients and longer appointment times for patients with learning disabilities.

Summary of findings

Care and treatment for patients was coordinated with other health and social care professionals to ensure patients received appropriate care. 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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

Staff felt supported by management and a clear leadership structure was in place. They were aware of their roles and responsibilities; however some of them did not understand the practice vision and values. There was a limited approach to obtaining staff feedback.

The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and / or were not always implemented by staff. Appropriate records were not always maintained in relation to the management of the service and regulated activities.

The systems in place for assessing and monitoring service provision were not always robust to ensure all risks were appropriately managed. Whilst clinical audits had been completed, we found there was no ongoing audit programme where they had made continuous improvements to patient care.

The practice actively engaged with the patient participation group (PPG) to seek patient feedback and improve the service. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

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

Requires improvement

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

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice offered proactive and personalised care to meet the needs of older people. Staff were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Older people had a named accountable GP and accounted for 6.6% of the practice population Fortnightly multi-disciplinary care meetings were held to ensure integrated care for older people with complex health care needs.

The practice ran a flu clinic each year, which was used to screen for other health conditions including atrial fibrillation (a heart condition that causes an irregular heart rate and a major cause of stroke) and memory concerns in the older population.

Erewash Clinical Commissioning Group (CCG) decided that each GP Practice be aligned to a specific care home so that each practice could offer care exclusively to one or more specific care homes. Patients could still be registered with a GP of choice.

The feedback received from one care home manager we spoke with was very positive. The GPs visited at least twice weekly and were described as being caring and very responsive to patients' needs.

People with long term conditions

Requires improvement

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

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice nurse had a lead role in chronic disease management and dedicated sessions for supporting patients manage conditions such as diabetes, hypertension and asthma were held. All these

Summary of findings

patients were offered an annual review to check that their health and medication needs were being met. Robust recall systems were in place to ensure patients attended. Longer appointments and home visits were available when needed.

The named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care for patients with the most complex needs. This included liaison with the acute care team to try to keep people at home and to avoid inappropriate hospital admissions where possible. Patients at risk of hospital admission were also identified as a priority and preventative action taken to address this.

Families, children and young people

Requires improvement

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

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients we spoke with and comment cards received showed the practice provided a caring and responsive service for children and young people. Parents told us their children and young people were treated in an age-appropriate way and were recognised as individuals.

The practice had systems in place to identify and follow up children living in disadvantaged circumstances; including safeguarding those who were at risk of abuse or not attending for their health checks.

The immunisation service for children was well-managed and included a weekly clinic on a Tuesday afternoon (1:30pm to 3:00pm) with the health visitor and a dedicated baby clinic for eight week assessments. Immunisation rates were high for all standard childhood immunisations with an uptake of 98% having been achieved. Parents could make a pre-bookable appointment to see the nurse or attend the weekly walk-in baby clinic.

Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. This included same day appointments being offered for urgent medical care. We saw good examples of joint working with midwives and health visitors to keep mothers, babies and children safe. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Antenatal and postnatal care was available with the doctor and midwife. A confidential contraceptive service was also offered by doctors and the nurse, including contraceptive pills, injectable contraception and natural family planning.

Working age people (including those recently retired and students)

Requires improvement

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

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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 some online services such as prescription requests as well as a full range of health promotion and screening that reflected the needs for this age group. This included travel advice, immunisation, family planning services, smoking cessation advice, cervical smears and alcohol screening.

Students who have moved away from the area could register as temporary patients during the school / university holidays. The practice offered “early bird” appointments between 7.30am and 8.00am on Tuesday and Wednesday and Friday; and was open until 6.30pm on all weekdays. This was particularly useful to patients with work commitments including telephone consultations where appropriate.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances. This included patients with a learning disability; children looked after in care and patients receiving palliative care.

Summary of findings

Annual health checks for people with a learning disability were carried out and longer appointments were offered to facilitate this. This feedback was confirmed by a manager of a supported living accommodation for people with learning disability.

The GPs were described as offering a good service that was responsive to patient's needs. Home visits were arranged and care planning was also promoted for these patients. A dedicated telephone phone number was also provided to enable them easy access to the practice.

The practice regularly worked with other health and social care professionals in the case management of vulnerable people. This included providing individualised care to patients requiring palliative care and liaison with the district nursing team.

The practice's joint working arrangements had promoted positive outcomes for patients in relation to risk assessment and management; as well as provision of responsive care.

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)

Requires improvement

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

Although the provider was rated as good for caring, effective and responsive they are rated as requires improvement for safe and well led domains. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had systems in place to ensure that patients with mental health needs attended their annual health reviews including medicines. The practice shared patient's physical health information with the psychiatrist and community mental health teams to inform the review of their care plan under the care programme approach (CPA).

The CPA is a national system which sets out how secondary mental health services and social services should help people with mental illnesses and complex needs. Staff told us this ensured coordinated care of physical and mental health services for patients.

The practice regularly worked with multi-disciplinary teams in the case management and advanced care planning of people with

dementia. The practice had introduced an improved referral pathway to the memory assessment service for patients with early signs of dementia. This had resulted in increased numbers of patients being offered memory assessments.

Patients with depression and anxiety had good access to an Improving Access to Psychological Therapies (IAPT) service in the locality. IAPT is a national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders.

A GP at the practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. 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. Some 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 spoke with eight patients during our inspection and their feedback was mostly positive. They expressed a high level of satisfaction about the care and services they received. Patients described the staff as friendly, caring and helpful; and felt they were treated with dignity and respect. They confirmed being involved in decisions about their care.

A few patients reported difficulty in getting a non-urgent appointment at times, however they were able to get an urgent appointment or telephone consultation where needed. This was also reflected in the six comments we received via Healthwatch.

Patients told us that the premises were clean and hygienic and that the facilities were accessible. Two patients said the waiting area was small and close to the reception area which meant they overheard some conversations at times. However, a notice informing patients that they could speak to staff in private if they wished was clearly displayed in the waiting area.

All but one patient said they felt listened to and were able to raise any concerns with staff if they were unhappy with their care or the service.

We reviewed 46 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. All comments were complimentary of the care and support provided, including continuity of care and the care for children.

We spoke with two members of the patient participation group (PPG) including the chair. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. They told us the practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of their feedback.

The national GP patient survey results showed that 88% of respondents would recommend Eden surgery to someone new; and 94% described their overall experience of this surgery as good. This was above the practice average for the Clinical Commissioning Group (CCG) of 71%. 111 patients had responded to this survey and the results were published in January 2015. The GPs own 2013 /14 patient survey focused on repeat prescriptions and the majority of patients were happy with the service.

Areas for improvement

Action the service MUST take to improve

- Ensure robust systems are in place for assessing and monitoring the quality of services provided. This includes arrangements for infection control, medicines management, staff training and development.
- Ensure documentary evidence of appropriate recruitment checks on staff is maintained.
- Ensure accurate records in relation to the management of the service and staff employed are kept. This includes having accessible and up to date policies and procedures in place for staff.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Ensure that staff are aware and identify with the practice vision and values.
- Ensure a register for all equipment used in the practice is kept for auditing purposes.
- Ensure outcomes from the innovative projects the practice is involved are collated as part of quality improvement work.

Eden Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP, practice manager and a second inspector.

Background to Eden Surgery

Eden Surgery is a suburban practice on the Nottinghamshire and Derbyshire border. The practice provides primary medical services from a single location to 3 709 patients in Ilkeston and Stanton. The practice population is predominantly white British with 93.4% of patients under the age of 75 years. The location where services take place is: Cavendish Road, Ilkeston, Derbyshire, DE7 5AN.

The practice is led by three GP partners, two male and one female. They are supported by a practice nurse who is also a partner, a practice manager, reception manager, one health care assistant, a phlebotomist, eight administrative staff and a cleaner. Eden surgery is a teaching practice for medical students in years one, two and five as well as nursing students. At the time of our inspection there one was medical student in training on placement at the practice.

The practice is open from 8:00am until 6:30pm each weekday with the exception of Tuesdays, Wednesdays and Friday's when an early morning surgery is available from 7:30am to 8:00am. The practice provides a range of services including minor surgery, maternity care, blood testing, vaccinations and various clinics for patients with long term conditions.

The practice also participates in the Erewash Hub service. This includes local GPs providing a GP service to patients within the locality between 4:00pm and 8:00pm daily as well as weekends between 09:00am and 2:00pm. This service is provided from the local community hospital.

The practice holds a Personalised Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community over and above the General Medical Services (GMS) contract.

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 practice had not previously been inspected and that was why we included them.

This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

- 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)

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included Erewash Clinical Commissioning Group, Healthwatch and NHS England Local Area Team.

We carried out an announced visit on 26 January 2015. During our visit we checked the premises and the practice's records. We spoke with a range of staff including the practice's GPs, specialist nurse, manager and administrative staff. We also spoke with external professionals who worked in liaison with the practice. These included the health visitor and two care home managers.

We spoke with eight patients who used the service including two members of the practice's Patient Participation Group. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We observed how patients were being cared for and reviewed 46 comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

All eight patients we spoke on the day of the inspection with told us they felt safe when using the service and raised no concerns about the practice. We found the practice used a range of information to identify risks and improve patient safety. This included reported accidents, untoward incidents and national patient safety alerts.

We reviewed incident reports and minutes of meetings where incidents were discussed within the last two years. This showed the practice had managed incidents over time, and so could evidence a safe track record.

Staff we spoke with were aware of their responsibilities to report safety incidents and near misses. For example, needle stick injuries were reported and a risk assessment completed to ensure the safety of both staff and patients.

We found the practice had a policy in place for responding to patient safety device alerts. The process included the practice manager receiving all patient alerts relating to pharmaceutical and equipment items via email. This information was disseminated to GPs to review via email and GPs then acknowledged receipt and having read the information.

GPs we spoke with told us alerts relevant to the practice were discussed in clinical meetings, and risks to patients were assessed and appropriately managed. However, staff at the practice could not when requested provide recorded evidence to demonstrate that these discussions took place and how other staff were made aware of actions taken in response to alerts. Following our inspection the practice submitted records to evidence that safety alerts had been discussed at a meeting held on 28 January 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were four records of significant events that had occurred during the last 12 months and we were able to review these. Clinical staff told us significant events were discussed at the clinical meetings and a process was in place to review actions from past significant events and complaints. The records reviewed showed the practice had learned from these and that the findings were shared with relevant staff.

For example, GPs were provided with computer print outs identifying allergies and / or adverse reactions for each patient they visited at home. This was in response to a significant event where a patient had been prescribed an antibiotic they had previously reacted to in error. In addition, GPs had access to a laptop during home visits to record their consultations and minimise the same mistake happening again.

Administrative staff we spoke with were aware of the process relating to reporting significant events, and they felt encouraged to do so. They acknowledged this was not regularly discussed unless it was relevant to their roles.

We advised the practice management that two of the significant events should have been reported to the Care Quality Commission (CQC) under the Health & Social Care Act 2008. This an incident investigated by the Police. The practice acknowledged this as an area of improvement and submitted the information within 48 hours of our inspection.

Reliable safety systems and processes including safeguarding

There were systems in place to manage and review risks to vulnerable children, young people and adults. For example, the practice highlighted all vulnerable patients on the practice's electronic records and included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans and their family members.

Clinical staff we spoke with were aware of how to document safeguarding concerns on the patient's electronic records including setting up alerts, making notes in patient summary and coding appropriately for the at risk register.

Training records we looked at showed all staff had received relevant role specific training on safeguarding children and adults. We asked members of the 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 to share information, document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for the agencies were accessible and included Derbyshire community health services safeguarding team.

Requires improvement

Are services safe?

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. GPs and the practice nurse were able to evidence they had done level three safeguarding and protecting children and / or adults training; this included identification, recognition and response to concerns. Not all staff we spoke with were aware who the GP lead was; however all felt confident to speak with a GP / practice manager if they had a safeguarding concern.

The practice had a chaperone policy in place but this was not visible to patients in the waiting areas on the day of our inspection. Staff told us information about chaperoning had recently been removed from the waiting area as this required updating. We were provided with the updated poster within 48 hours of our inspection and assured it was displayed in the patient waiting area and consultation rooms.

Receptionists we spoke with understood their responsibilities when acting as chaperones. We were told that relevant staff had received verbal and online training to enable them to carry out this role effectively. However, staff at the practice could not when requested provide recorded evidence to demonstrate that staff who undertook this role had received the necessary training. In addition, no risk assessment had been carried out to support the decision to not have a DBS check for these staff. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children.

Medicines management

Patients told us that the system for obtaining repeat prescriptions generally worked well and enabled them to obtain further supplies of medicines. Repeat prescriptions were often processed within 48 hours by the practice and could be requested in person and via the internet.

The patient participation group (PPG) had undertaken a repeat prescription survey in February 2014 and had received 200 responses. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The results showed 87% of patients felt the practice dealt with their prescription request quickly and efficiently; and 88% had no problems with their repeat prescription over the last six to 12 months.

The practice was not able to provide us with a written policy or protocol for repeat prescribing; although GPs told us systems were in place to monitor repeat prescribing for patients receiving high risk medicines. Prescriptions were reviewed and signed by a GP before they were given to the patient and this was confirmed by staff we spoke with. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We checked medicines stored in the treatment rooms and refrigerators and found they were kept securely. However, robust systems were not always in place to ensure that all medicines were in date, suitable for use, and stored appropriately. For example, we noted temperatures slightly above the manufacturer's recommendation of between two and eight degrees had been recorded for one of the fridges. We discussed this issue with the practice management during the inspection and they took immediate action to address this matter.

The practice addressed this as a significant event and liaised with NHS England, Erewash Clinical Commissioning Group (CCG) and Public Health. The outcome of the analysis showed the manual recording of the temperature was not being completed correctly by the relevant staff member and they were not aware of the implications should vaccinations be stored above the recommended temperatures. We were told within 48 hours of our inspection that all relevant staff had received refresher training and the practice nurse would be undertaking monthly audits to ensure the safety of all medicines.

The practice was able to confirm that the vaccinations had been stored at appropriate temperatures as evidenced by the temperatures recorded electronically by the inbuilt thermosense thermometer. We were assured by the practice staff that the vaccines were still safe for use, having been stored at the correct temperatures.

We found the system in place for the management of controlled drugs such as diamorphine was not robust in relation to the competence of staff responsible for recording and handling the medicines. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse which included regular monitoring in line with national guidance.

We found the senior receptionist had day to day responsibility for ensuring the records of receipt and

dispensing balanced with the quantity of each controlled drug held by the practice. We were told these checks were undertaken together with the attached pharmacy technician. A GP partner retained overall accountability for controlled drugs in line with the practice policy. However, there were no formal records to confirm that the non-clinical staff member had undertaken relevant training and that a GP regularly supervised their work.

In addition, we found keys for the controlled drugs cupboard were not held securely and staff who were not authorised to access controlled drugs had access to the keys. This was not in line with the practice policy which clearly stated the key to the cabinet would be kept separate from any other keys and only designated practitioners would be authorised to gain access to the keys.

After our inspection we were told the keys were now locked away and could only be accessed by clinicians. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area including their destruction.

GPs had not undertaken audits of controlled drug prescribing within the last twelve months to look for unusual products, quantities, dose, formulations and strength. However, they received regular input from the CCG pharmacist and pharmacist technician. Records we looked at showed the clinicians' prescribing practices were regularly reviewed and compared with other practices within the locality to drive improvement.

We reviewed the practice records relating to the number of vaccines kept in stock between November 2014 and January 2015; and found clear records were not always kept in relation to the stored medicines. This was highlighted to the practice leadership on the day of our inspection. However, within 48 hours after our inspection we were provided with improved records to evidence the date the vaccines were checked and by whom, the number of vaccine doses in stock and expiry date.

Cleanliness and infection control

Patients told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be clean and tidy.

The practice nurse was the designated infection control lead for the practice. The lead nurse had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.

Training records showed that all staff had received initial infection control training and annual refresher training for areas such as hand hygiene were required as stipulated in the checklist used to audit infection control measures within the practice.

The practice manager told us all staff at risk of exposure to Hepatitis B infection, were immunised against this. However, records evidencing the immune status of staff or risk assessments for staff that may have declined the vaccine were not readily available on the day of our inspection. For example, in one clinical staff file the Hepatitis B immunisation had been dated 2005 and recommended a further booster in five years; we found no follow-up had been made. This was discussed with the practice manager to follow-up to ensure that staff and patients were protected against identifiable risks of infection.

The lead for infection control told us that senior staff carried out regular checks to ensure that the premises were clean and hygienic, although this was not always recorded as stipulated in the policy. For example the policy stated that an unannounced inspection will take place on at least a quarterly basis and the findings will be reported to the partners' meeting for any remedial action.

Records reviewed showed the practice had only documented one inspection since it had been registered with the Care Quality Commission in January 2013. The infection control audit had been completed in November 2014. The management acknowledged this as an area of improvement and the practice manager told us they had obtained the CCG template for infection control risk assessment and would use this form for future auditing.

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. Protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Records reviewed showed the landlord of the building had commissioned an external contractor to carry out a Legionella risk assessment on 28 October 2014 and a schedule was in place to undertake regular water sampling

tests to reduce the risk of infection to staff and patients. We spoke with one of the contractors during the inspection and they discussed in detail the checks they undertook on a daily, weekly and monthly basis. The contractor showed us certification to confirm they were a qualified Legionella risk assessor.

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 tested annually and stickers were displayed indicating the last testing date. We saw that the last portable appliance testing had been completed on 08 April 2014 and an update had been scheduled for April 2015.

We saw evidence of calibration of relevant equipment for example weighing scales. However, the practice did not have an asset register / inventory of all equipment available and in use, to ensure that all equipment had been checked at the required intervals.

Staffing and recruitment

Most of the staff had worked at the practice for a number of years and five of them had been employed for over 15 years. This ensured continuity of care and services for patients. Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe.

We saw that a rota system was used to plan and monitor staffing levels to ensure that enough staff were on duty; although no formal review or analysis had been undertaken of staffing levels. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was an arrangement in place for members of staff to cover each other's absences to ensure sufficient staff were available to meet patients' needs.

We reviewed four staff files and found two staff files included proof of identity and a photograph, evidence of qualifications, skills and experience and legal entitlement to work in the UK. Professional registrations for individual doctors and nurses were in date and they were allowed to work by the General Medical Council and Nursing and Midwifery Council.

However, one recently employed staff member did not have satisfactory information relating to criminal record checks on their file. There was no clear recorded rationale for the decision not to carry out a DBS check on staff and / or follow-up on any missing information. This included staff who undertook chaperoning duties.

We also found two staff records did not contain written references, a signed contract / job description as required by the provider's own policies before staff started working at the practice. The evidence led us to conclude that the provider did not have effective recruitment and selection processes in place to ensure that all relevant checks and documentary evidence had been obtained before staff began work.

The practice recruitment policy referred to obtaining medical examinations when staff were recruited: however this was not evident in the files we reviewed. The provider was unable when requested to provide any written evidence to demonstrate how they assessed that each member of staff was physically and mentally fit for the role they were employed to do.

Monitoring safety and responding to risk

The practice had systems and procedures in place to manage and monitor risks to patients, staff and visitors to the practice. The landlord of the practice building was responsible for the maintenance checks of the building. We found suitable arrangements were in place to ensure that the premises were appropriately maintained and safe.

A report produced by the landlord and dated 30 April 2014 showed annual checks relating to fire audits, water risk assessments, testing of electricity distribution, lifting equipment, gas and lighting were compliant with checks undertaken.

An external contractor was also responsible for undertaking daily and weekly checks of fire alarm systems, emergency lighting, basic ground maintenance and health and safety checks for example. We saw records to confirm this took place.

The practice had a health and safety policy in place and all new staff received training as part of their induction. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Staff we spoke with told us that they had attended fire safety training and records we looked at confirmed this.

Requires improvement

Are services safe?

Records showed an annual fire drill was undertaken in December 2014 to ensure that staff and patients knew how to evacuate the premises and what to do in the event of a fire. The provider may wish to note that the previous fire risk assessment completed in December 2012 recommended that fire drills be carried out twice yearly. The practice had a fire risk assessment completed in December 2014 by an external contractor and the report was yet to be shared with the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff we spoke with knew the location of the emergency equipment and medicines. The clinical staff said that they had access to sufficient equipment to deal with emergencies.

Emergency equipment available included access to an automated external defibrillator (AED) although staff did not have access to oxygen. An AED is a portable electronic device used to attempt to restart a person's heart in an emergency. Records were available to show that all staff had received annual refresher training in cardio pulmonary resuscitation (CPR) and the use of the AED.

Emergency medicines were available in a secure area of the practice. 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.

Staff were able to identify and respond to risks to patients including deteriorating health and well-being or medical emergencies. For example, emergency procedures were in place to deal with patients that experienced a sudden deterioration in health.

One GP told us patients experiencing a mental health crisis were referred to the crisis team or directly to the duty psychiatrist; and acutely ill children and young people would be referred to the children's emergency department, paediatric on call or to the acute medicine.

A disaster recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. We noted this was last reviewed in March 2013 and some aspects of the business plan required updating to reflect the current systems in place and to be shared with all staff to increase awareness. The business plan also referred to the PCT, which no longer exists.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they received appropriate care and treatment and this was supported by comment cards we received. We found patient needs were assessed and they received effective care and treatment to meet their needs. This included referrals to secondary and community care services when required.

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

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 had access to the latest guidelines from the National Institute for Health and Care Excellence (NICE) via the internet; and through attendance at educational events and Erewash Clinical Commissioning Group (CCG) meetings. The CCG is a group of GP practices that work together to plan and design local health services in England. They do this by commissioning or buying health and care services.

We found limited formal records to evidence that new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed in clinical meetings; although GPs told us this took place.

The practice used a risk stratification tool (RISC) to ensure that patients had their needs assessed and that care was planned and delivered proactively. For example, RISC was used to identify patients most at risk of unplanned hospital admissions. Care plans were then developed in collaboration with patients, their carers and professionals involved in their care. By using this system the clinical team aimed to ensure that each patient received appropriate interventions of care within their home and minimise unnecessary admissions to hospitals.

The practice also used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice offered a range of enhanced services for example dementia screening and alcohol-related risk reduction scheme. The practice had met their initial targets for offering memory assessments for patients at risk of dementia and had completed 3% of care plans in the first three months of the service being offered.

The 2013/14 Quality Outcomes Framework (QOF). QOF is the annual reward and incentive programme detailing GP practice achievement results. The data showed the practice had achieved a 76.1% dementia diagnosis rate for identified patients at risk and 72.7% of these patients had received a care plan review. This was above the national average of 54.3% dementia diagnosis rate.

These positive outcomes had largely been achieved through identifying patients at clinical risk of dementia in line with national guidance and following up on patients / carers who raised memory concerns. One of the GPs was the clinical lead for dementia and had introduced the improved referral pathway for Erewash memory assessment service.

We were shown data of the practice's annual performance for prescribing in comparison to other practices within Erewash CCG. The data showed the practice was the second lowest in the CCG area prescribing practice for hypnotics (prescribed for insomnia / difficulty in sleeping) and non-steroidal anti-inflammatory drugs (NSAIDS); and the highest in prescribing Nutricia (oral nutritional supplements) and blood glucose test strips which is interpreted as being good.

The data also showed areas of improvement and the practice had an action plan to address these with input from CCG pharmacist and pharmacy technician.

Management, monitoring and improving outcomes for people

The GPs told us they had special interests in specialist clinical areas such as rheumatology, minor surgery, mental health, dementia and women's health The practice nurse supported this work which allowed the practice to focus on specific long term conditions. Clinical staff we spoke with told us they were open about asking for and / or providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines relating to improving patient care.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data we looked at related to: GP

Good

Are services effective?

(for example, treatment is effective)

referrals to six specialities including dermatology, general surgery, gynaecology, urgent care emergency admissions and accident and emergency. The data showed the practice had better / comparable outcomes to most of the other practices in the Erewash CCG area.

For example, the practice had the second lowest rate of emergency admissions in the CCG between April and September 2014 and this was linked to the proactive arrangements in place to reduce avoidable admissions. This included facilitating fortnightly integrated care meetings (also known as community delivery team meetings) to review and monitor the care needs of patients seen in Accident &Emergency (A & E), recently discharged from hospital and those with complex care needs.

A review of the meeting minutes showed discussions held, actions identified and the review at a follow-up meeting. We were also told the duty doctor for each day was responsible for reviewing patients within 24 hours of their hospital discharge.

All GPs we spoke with demonstrated awareness of using national standards for the referral of urgent, two weeks and elective referrals. We noted that some of clinical records evidenced reviews of elective and urgent referrals made, and improvements to practice were shared with all clinical staff. The practice maintained a referral log to monitor the number of referrals made and this enabled the practice to audit referral numbers and timescales in which they had been made.

The practice also used the information collected for the quality outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures in line with best practice guidelines.

We found the practice performance to be above the national and local average for the number of patients with diabetes who had an annual medication review; and the practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease, child immunisations and dementia care. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us three clinical audits that had been undertaken in the last 12 months. These related to a review of ear, nose and throat (ENT) referrals, treatment for atrial fibrillation (a heart condition that causes an irregular heart rate and a major cause of stroke) and clinical referral letters to health professionals in secondary care. The latter audit was a completed audit cycle and the practice was able to demonstrate the changes resulting since the initial audit.

For example, the first audit cycle of referral letters resulted in the GP creating a checklist of information to include in all referral letters so as ensure sufficient information was provided. This included the reason for the referral, current management of the patient's health condition, the patient's and GP expectations from the referral.

The second audit cycle showed improvement in the content of the referral letters was still required as some of the referral letters did not consistently meet the specified criteria. However, the GP had taken action to address this to improve information shared with other professionals.

The practice implemented the gold standards framework for end of life care. It 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a long serving team who knew their population group needs well. We reviewed staff training records and saw that most staff had attended courses such as information governance, safeguarding adults and children, cardio pulmonary resuscitation (CPR) and use of a an automated external defibrillator (AED).

We found not all clinical staff training records and supporting certificates were held centrally by the practice or could be located promptly when required. This was discussed with the practice manager and they assured us this would be addressed post our inspection.

Staff we spoke with told us they had received appropriate induction training to enable them to carry out their work and they worked well together as a team. We saw that new staff completed a generic induction programme. The staff induction forms we looked at were not always signed and dated to confirm the induction had taken place; although the respective staff member we spoke with confirmed it had happened and they had received essential information to carry out their work.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they were supported to maintain and develop their skills and knowledge and this included on-line and face to face training.

All GPs were up to date with their yearly continuing professional development requirements. One GP had been revalidated and two GPs were due for revalidation in 2015. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

We found the practice nurse was expected to perform extended roles and they were able to demonstrate they were trained to fulfil these defined duties. For example, the administration of vaccines, cervical cytology and family planning and nurse prescribing. They were able to see patients with long-term conditions such as asthma, coronary heart disease and diabetes. They also worked as a contraception and sexual health nurse and brought this expertise to the practice.

Working with colleagues and other services

The practice had identified where there was a high prevalence of long term conditions within the practice population so as to ensure appropriate services were offered. This included conditions such as transient ischaemic attacks (TIA or "mini stroke" is caused by a temporarydisruption in the blood supply to part of the brain), dementia, asthma and atrial fibrillation (a heart condition that causes an irregular heart rate and a major cause of stroke.).

The practice worked with other health and social care professionals to ensure a coordinated approach in monitoring patient outcomes, meeting patient's individual needs and enabling them to remain at home, where possible.For example, fortnightly multi-disciplinary meetings were held to discuss the needs of patients with multiple and complex needs such as those receiving end of life care, children on the at risk register, patients at risk of hospital admissions and / or with mental health needs.

These meetings were attended by health professionals including members of the palliative care team, midwife, health visitor, district nurse, social worker, and community matron and care co-ordinator.

Decisions about patients' needs 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. We noted that some clinical staff had been unable to attend the meetings due to not working on days when the meetings were held. This was highlighted to the practice management to review the participation of all the staff members and / or effective sharing of meeting minutes.

The GPs attended the CCG monthly provider group meetings to share best practice and discuss service provisions within the locality. This included participating in the CCG led Erewash Hub service which comprised of local GPs providing appointments from 4:00pm to 8:00pm daily and 9:00am to 2:00pm at weekends to patients from the local community hospital. The practice manager attended regular practice forum meetings with other managers to share information and provide peer support.

The practice had effective systems in place for the sharing of appropriate information in relation to the coordination of each patient's care. For example, the practice 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 electronically, by post and fax. The incoming results were usually reviewed by the duty doctor within 24 hours of receipt. The GP who saw these documents and results was responsible for the action required.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Information sharing

The practice used several electronic systems to communicate with other providers. This included the SystmOne electronic system to coordinate and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that patients test

Good

Are services effective?

(for example, treatment is effective)

results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly reviewed, coded and followed up by the GP where required.

There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. For example, the practice alerted the out-of-hours provider to any patients who may be vulnerable or who may require assistance by creating a special note on the patient record or sharing a right care plan. A right care plan is devised with the patient by their own GP or other health care professional and then shared with Derbyshire Health United (DHU) via secure e-mail. The plan is valid for up to six months and is kept on a database at DHU which is the out of hours GP service in Derbyshire.

The practice was signed up to the enhanced data sharing model (eDSM) (summary care record) and planned to have this fully operational by the end of March 2015. This model would allow the practice to share and receive information from other local departments and clinics such as physiotherapy, district nurses and the smoking clinic. Patients were being encouraged to give or withdraw their consent to the use of eDSM.

Electronic systems such as choose and book were also in place for making referrals to ensure these were made promptly. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported this system was easy to use.

Consent to care and treatment

The January 2015 national GP patient survey results showed GPs and nurses were very good at involving patients in decisions about their care. For example, out of 111 respondents 96% respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care, 97% said the nurse was good at explaining tests and treatments and 98% had confidence and trust in them.

The GPs and nurses we spoke with were told us risks, benefits and alternative options to care and treatments were discussed and explained in a way that each patient was able to understand. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown examples of documented consent for flu vaccines and for minor surgery as well as the policies for obtaining patient consent. The policies highlighted how patients should be supported to make their own decisions and how these should be documented in patient's records.

Staff we spoke with were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their day to day practice. This included supporting patients with a learning disability and those with dementia to make decisions through the use of care plans, which they were involved in agreeing. These care plans had a section stating the patient's preferences for treatment and decisions; and were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

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 when interviewed. This included involving the patient's relatives and professionals involved in their care when discussing do not resuscitate decisions.

All clinical staff demonstrated a clear understanding of Gillick competencies. These competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Training records for administrative staff showed some of them had received training in the Mental Capacity Act and Deprivation of Liberty (DOLs), dementia and learning disability awareness to inform their practice.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. New patients completed a form, which provided some information about their lifestyle and health. We saw that a variety of health promotion information was available to patients and carers on the practice's website and the noticeboards in the waiting area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved an uptake of 98% childhood immunisation rates and 95%

Good

Are services effective?

(for example, treatment is effective)

uptake for the influenza vaccination to patients with chronic obstructive pulmonary disease (COPD) and diabetes. The practice's performance for all immunisations was above average for the CCG and a system was in place for following up non-attenders. Patients could access information, advice and support from the Derbyshire alcohol service worker who visited the practice.

Records reviewed showed that clinical staff offered opportunistic screening to patients using technology such as 24 hour blood pressure monitoring machine, blue tooth electrocardiogram / ECG (equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.) machine and WatchBP device used in detecting atrial fibrillation (a heart condition that causes an irregular heart rate and a major cause of stroke).

One of the GPs and also the clinical CCG lead had participated in the atrial fibrillation detection programme between June 2012 and January 2013. This programmed aimed to identify patients with atrial fibrillation and ensure that they received appropriate preventive treatment to reduce stroke occurrences. The CCG conclusion was that it "helped to deliver an innovative and effective stroke prevention programme" which enabled identified patients to receive effective care.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years, an annual review to patients with a learning disability and also checked that all routine health checks were completed for long-term conditions such as diabetes. The practice's performance for cervical smear uptake was 86% in 2013/14, which was better than the national average of 81.9%. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All the eight patients we spoke with described the staff as friendly, helpful and caring; and felt they were treated with dignity and respect. Three of the patients particularly felt valued in that staff addressed them by their preferred name. The positive feedback about the way staff treated patients was reflected in the results of the national GP patient survey published in January 2015.

For example: out of 111 responses, 93% of respondents said the receptionists were helpful; 91% said the last GP they saw or spoke to was good at treating them with care and concern; 88% would recommend this surgery to someone new and 94% described their overall experience of this surgery as good. We observed patients were spoken with in a professional and friendly manner by staff, both on the telephone and face to face.

Patients completed comment cards to tell us what they thought about the practice. We received 46 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a very good / excellent service and staff were efficient, understanding and caring. They said they were satisfied with the care provided and that their dignity and privacy was respected.

Some of the comment cards detailed examples of good care provided for children and patients with long term conditions. Families, children and young people were treated in an age-appropriate way and recognised as individuals with their preferences considered.

Staff we spoke with demonstrated awareness of maintaining patient confidentiality; and a notice informing patients that they could speak to staff in private was clearly displayed in the waiting area. Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room.

We observed the doors of the consultation and treatment rooms were closed during consultations and that conversations taking place in these rooms could not be overheard. Curtains were also provided so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

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. There was a 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. This included data from the national GP patient survey published in January 2015. The results showed the majority of 111 practice respondents said the GP and nurses were good at: listening to them, giving them enough time, explaining tests and treatments, and involving them in decisions about their care.

Most of the results were above the average for all practices in the Erewash Clinical Commissioning Group (CCG). The CCG is a group of GP practices that work together to plan and design local health services in England. They do this by commissioning or buying health and care services. For example: 93% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG average 90%) and 88% respondents said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 82%).

These results were supported by comments made by patients we spoke with during our inspection and comment cards we received. For example, patients told us their 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.

We saw examples of agreed care plans for patients receiving end of life care, complex long terms conditions and dementia. A priority number for contacting practice staff was detailed in their care plans to ensure they could receive appropriate support when needed.

Feedback received from one care home manager for older people was very positive about the GP service provided.

Good

Are services caring?

GPs were reported as attending the care home twice weekly which had promoted continuity of care. GPs were said to provide a caring service and were involved in care planning where appropriate.

The 2013/14 Quality and Outcomes Framework (QOF) data showed all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their patient record in the preceding 12 months. 73% of patients diagnosed with dementia had received a face to face review in the preceding 12 months. QOF is the annual reward and incentive programme detailing GP practice achievement results.

The waiting area and practice website included health information for different population groups to support them in understanding their health conditions. For example, asthma, diabetes, mental health and minor ailments. Staff we spoke with told us patients were involved and encouraged to be partners in their care and in making decisions.

Translation services were also available for patients who did not have English as a first language to ensure effective communication and involvement about their health care needs. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Two patients we spoke with confirmed being signposted to support services to help them manage their treatment and care. Two comment cards also highlighted that staff had responded compassionately when the patient needed emotional support. This was following a family member's cancer diagnosis and treatment, and when a patient's partner had passed away.

Staff we spoke with gave examples of how they responded compassionately when patients needed support to cope with their care and treatment. This included: telephone calls to patients / carers who had suffered bereavement or had a diagnosis of life threatening condition such as cancer; referrals to social services for community care assessments and multi-disciplinary working with other health professionals to address risks to patient's emotional well-being.

We were told telephone calls were either followed by a patient consultation at a flexible time and location to meet the family's needs or giving them advice on how to find a support service.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. These included Nottinghamshire bereavement trust and support groups for carers, patients with dementia, alcohol and mental health needs. The practice's computer system alerted GPs if a patient was also a carer.

We were shown the written information available for carers to ensure they understood the various avenues of support available to them. GPs we spoke with told us patients with depression and anxiety were also referred to talking therapy / counselling services with their consent where appropriate.

Patients had access to a citizen's advice bureau advisor who worked closely with the practice. A weekly surgery was held at the practice to provide various support and advice to patients, including financial matters. The surgery was available on Wednesdays between 9:30am and 1:00pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Most patients we spoke with reported the practice was responsive to their care needs and ensured they received appropriate care when they needed it. For example, one parent told us they were concerned over their child's wellbeing after they had bumped their head. They rang the practice and were offered a same day home visit by the GP. Two other patients with long term conditions told us they usually saw the same GP and nurse, therefore continuity of care was maintained.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. This included services being planned, delivered and coordinated to take account of patients with complex needs. For example, those living with dementia, a mental health need and / or long term health conditions.

Two managers we spoke with for services providing care to older people and learning disability confirmed patients had their health needs proactively managed; and requests for medicines, urgent home visits, appointments and advice was accommodated.

Multi-disciplinary meeting minutes reviewed showed specific examples were the practice had worked in liaison with other professionals to respond to identified risks to patients' health and provide integrated person-centred pathways of care. For example, plans were put in place to minimise significant risks to a patient with a diagnosis of dementia and multiple long term conditions to ensure their health care needs were monitored regularly. Memory assessments were also offered to patients at risk of developing dementia and personalised care plans put in place to address their needs.

The practice pro-actively encouraged patients on the severe mental illness (SMI) register to attend for their annual health and medicines reviews. This information was then shared with the psychiatrist and community mental health team as part of their care programme approach (CPA) annual reviews. The CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.

Staff told us the sharing of information provided better integration of physical and mental health services for their patients. A comment card gave an example of how a GP had effectively responded to a patient experiencing a mental health crisis at their home.

The 2012/13 Public Health England information showed approximately 53% of the practice population had a long-standing health condition; and the practice had clinical leads for a variety of conditions to address this. This included adult mental health, dementia, atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and rheumatology.

All patients with long term conditions were invited for annual reviews in relation to their physical health and medicines reviews. Feedback from most patients showed they had timely access to appointments for an initial assessment, diagnosis and for treatment or on-going management of chronic conditions.

Weekly, nurse-led clinics were held for conditions such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and asthma; with input from the GPs and community specialists. Other weekly clinics provided related to antenatal and postnatal care, family planning and child health; of which a health visitor was available on a Tuesday afternoon for advice on child development.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. (The CCG is a group of GP practices that work together to plan and design local health services in England. They do this by commissioning or buying health and care services).

We saw records where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example the practice was involved in a local hub service managed by the CCG to increase appointment availability for patients within the Erewash CCG area. This service was offered at the local community hospital, and local GPs provided extended appointments from 4pm to 8pm daily and 9am to 2pm at weekends to patients. One of the GP partners had been a founder of the hub service and on the afternoon of our inspection was providing care to patients as part of this service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. For example, the practice had included links to the British heart foundation on its website in response to suggestions made by the PPG following a health promotion campaign within the area. The practice also worked with a number of voluntary organisations recognising the need to support patients' emotional well-being as well as their physical health needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning and delivery of its services. This included taking account of factors such as age, disability, gender, pregnancy and maternity status, religion and language. Reasonable adjustments had been made to remove barriers for patients to access services. For example, the practice was situated over the ground floor and there was sufficient space within the waiting area, consultation rooms and corridors to manoeuvre a wheelchair and prams.

A portable hearing loop was available for people with a hearing impairment. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had reviewed the suitability of the facilities and premises for patients with physical disabilities with a member of the PPG. This was to ensure that disabled patients could access and use services on an equal basis to others.

One patient we spoke with commented that the second front door was heavy and difficult to open as it was not electronically operated. The practice management were aware of the concerns and were limited in the action they could take as the building was owned by another provider.

The practice population was predominantly English speaking patients though it could cater for other different languages through interpreter and translation services. Information on the practice website could be translated into 90 different languages including French, Polish and Afrikaans. Information about the role of NHS for newly arrived persons in the UK including those seeking asylum was also published on the practice website. The information was available in 20 different languages and covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register as a patient and how to access emergency services.

Students who had moved away from the area were offered appointments during holidays using temporary registration when requested. The practice had a system for flagging vulnerability in individual patient record so that the length of appointment could be tailored to meet their needs.

We were told the practice worked with families to ensure any children or the elderly patients were seen as a priority. This was confirmed by patient feedback we received. If reception staff were particularly concerned about the well-being of a patient in the waiting room they were able to send instant alerts to the GPs.

GPs and the nurse we spoke with told us they always considered patients spiritual, ethnic and cultural needs, alongside their medical needs when delivering care and treatment. The practice should consider providing equality and diversity training for staff to ensure they are all aware and promote anti-discriminatory practice within the practice.

Access to the service

The January 2015 national GP patient survey results showed 111 patients rated the practice positively in relation to phone access and appointments. For example: 96% of respondents found it easy to get through to the surgery by phone (Erewash CCG average was 77%); 86% of respondents described their experience of making an appointment as good (CCG average was 77%); and 80% of respondents usually get to see or speak to a GP (CCG average was 53%). The results were above average for all practices in the Erewash CCG area.

This data was also reflected in the patient feedback we received. Most patients we spoke with told us they were satisfied with access to the service and the appointments system was easy to use. They confirmed they could see a doctor on the same day if in urgent need of treatment. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Comment cards received showed patients were able to obtain a convenient appointment or telephone

Good

Are services responsive to people's needs?

(for example, to feedback?)

consultation when needed. However, a few patients reported difficulty in getting a non-urgent appointment at times as well as experiencing waiting times for some specific doctors.

This was discussed with the practice management. They explained that the practice booked non-urgent appointments with the GPs only one week in advance to reduce the number of appointments not attended. This was supported by the analysis the practice undertook on a monthly basis. For example, in the month of January 2015 only 41 out of 1576 appointments had not been attended; this represented a low rate of 2.6% "do not attend appointments" (DNAs). The practice acknowledged they would review the patient feedback.

Comprehensive information relating to the practice opening times and appointment system was available to patients on the practice website and within the practice. This included how to access the right care at the right time. For example, urgent appointments during the day and out of hours, as well as home visits.

The practice was open from 8:00am to 6:30pm on Mondays and Thursdays; and from 7:30am to 6:30pm on other weekdays. Derbyshire Health United provided the out of hour's service to patients needing urgent medical assistance when the practice was closed.

We reviewed the accessibility and appointment system and found provisions had been made to ensure patients from different population groups could access services in a way and time that suited them. For example, the practice had protected same day appointments and each GP had at least six emergency appointments available each day. GPs told us they had capacity to increase the number of appointments offered when one of them was on leave to ensure they maintained the same level of access for patients.

The practice offered pre-bookable early morning appointments from 7:30am to 8:00am on a Tuesday, Wednesday and Friday; and this enabled working age patients to attend. The practice took part in a CCG pilot which included offering appointments on a Saturday and Sunday between January and March 2013. The practice found a poor uptake of appointments on Sundays and this influenced the introduction of early morning appointments. The practice was also looking to introduce online appointments for patients to further improve online access.

Home visits and longer appointments were available for patients with long-term conditions, mental health needs, learning disabilities, older people and those who needed them. This also included appointments with a named GP or nurse. Appointments were usually 10 minutes in length, but 20 minute slots were available if required. Annual reviews were usually completed within 30 minutes. Appointments were also available outside of school hours for children and young people to attend.

We found the practice had processes in place to review patient access to appointments and services in liaison with the patient participation group (PPG). The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. This included the use of surveys to promote awareness of the opening times, clinics held within the practice and online services.

For example, the 2012/2013 PPG survey results showed 86% of respondents were aware of the opening times, 89% were knew the services offered by the advance nurse practitioner and 89% knew they could obtain a same day emergency appointment by ringing the surgery at 8am or at 1pm for an afternoon appointment.

Listening and learning from concerns and complaints

Patients we spoke with told us they had no cause to raise complaints and would complain to the reception staff, practice manager or GP if they needed to. We found the practice had a system in place for handling complaints and concerns. This included information being made available to help patients understand the complaints system. For example, the complaints procedure was displayed in the reception / waiting area and information about the complaints procedure was available on the practice website and in the practice leaflet.

The practice manager was responsible for managing complaints and ensuring that an investigation was carried out when appropriate. They told us they had not received

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaints in 2014, but had received four complaints the previous year. The complaints had been recorded, investigated and responded to; including issuing of an explanation and written apology.

Each complaint was analysed to establish if the situation could have been handled differently. Staff we spoke with told us there was openness and transparency in how concerns and complaints were dealt with. The practice may wish to note that one patient told us they had raised a complaint two years ago but had not followed through this process due to not being directed to the right person to discuss their concerns.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice leadership told us the ethos of the practice included providing evidence based healthcare, acting with integrity and reducing health inequalities. The statement of purpose encompassed key values such as partnership working with patients and health professionals, delivery of high quality care, mutual respect between patient and staff, as well as improvement of services. All staff we spoke with were clear that they aimed to provide patients with the best quality care.

However, discussions with staff showed some were not clear about the overall vision of the practice; and they told us insufficient time was allocated to the future planning of an overall strategy for service development. We found no records to evidence that the leadership had discussed and agreed the practice vision and areas of development with all staff.

Governance arrangements

The practice had various policies and procedures in place to govern the activities carried out. We found the system to ensure that all policies were regularly reviewed, kept up-to-date and shared with staff was not robust. The practice manager acknowledged they were in the process of updating the policies and a schedule to review all policies would be put in place after our inspection. We noted in some cases there were two policies relating to a specific area which had the potential to confuse staff. For example, there were two child safeguarding children policies in the folder.

The practice had some systems in place to assess and monitor the quality of services. However, we found areas where robust systems were not always in place to provide assurances that the practice policies were being followed in line with recommended guidance. For example, implementation of recruitment procedures, audits related to infection control checks and monitoring the storage of vaccines.

We found the related practice policies were not always being followed and the management had not identified this risk and taken appropriate action to mitigate potential risks. Within the small team it was evident that a few staff were not always fulfilling their assigned lead responsibilities to ensure that the service was well led.

The practice leadership was able to demonstrate commitment to improving the quality of care and services provided to patients; however we found there was no strategic plan as to how the practice intended to include completed audits as part of its process to continually improve quality. For example, the practice offered minor surgery as a service and no clinical audits had been undertaken to audit the results, complications and diagnostic accuracy of treatment provided.

Leadership, openness and transparency

The leadership structure included three GPs, a practice nurse, a practice manager and reception manager. Most of the staff were clear about their roles and responsibilities, and felt that the practice was well led. Staff described the culture of the organisation as supportive and open, and felt able to raise any issues with senior managers and / or GPs as they were approachable. The practice manager was described as having an open door policy to discuss any concerns or suggestions.

A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it. Whilst various internal meetings were held, not all staff had the opportunity of attending relevant team meetings, to enable them to share information and to raise any issues.

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

The practice had gathered feedback from patients through patient surveys, the family and friends test and from the patient participation group. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The practice manager showed us the analysis of the most recent patient survey, which was considered in conjunction with the PPG.

The 2013/14 survey focused on medicines and the prescription service. The survey results showed 84% of the patients felt the staff dealt with their requests quickly and efficiently and 77% of patients had not used the practice website site to order their prescriptions. An action plan was put in place to promote the online service. This included notices being displayed in the reception, newsletter and on the website. The results and actions agreed from these surveys are available on the practice website for review.

The practice had an active patient participation group (PPG) which had been established in 2011 and met every

Are services well-led?

Requires improvement

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

quarter. We spoke with two of the members including the chair. They told us the PPG included seven patients from the following population groups: working age, those recently retired, older people, and people with long term conditions and / or caring responsibilities. The practice was aware that younger people were underrepresented and they had been given an opportunity to join the virtual group by email but had not taken the opportunity to do so.

The PPG described the practice management as very engaging and collaborative in ensuring that the patient voice was heard in improving services. We were told that patient feedback about the service was very positive and where concerns were raised, these were shared with the management via the practice manager and / or GP who attended the meeting.

We found very limited input to demonstrate non-clinical staff were involved in the development of practice services. For example, there were no regular and planned staff meetings to discuss practice issues, and feedback from non-clinical staff was not actively sought. The practice manager told us plans were in place to formalise practice team meetings and one had been scheduled for 20 February 2015.

Management lead through learning and improvement

We found all three GP partners were actively involved in activities such as research, teaching, and participating in pilot projects within the Erewash clinical commissioning group. This was reflective of the practice's ethos of the surgery being a learning organisation which provided evidence based healthcare and aimed to reduce health inequalities. The clinicians were individually responsible for maintaining their clinical professional development through training and mentoring.

They told us that the outcome of clinical audits and reviews of significant events were shared with staff at clinical meetings to ensure the practice improved outcomes for patients. However, we found limited records to confirm these activities took place. The practice management had already identified this as an area of development including formalising learning opportunities in practice meetings. We noted that the practice nurse was not able to attend the clinical meetings as they did not work on the day. Therefore nursing input was limited.

We looked at four staff files and saw that for two of them, an annual appraisal took place which included a personal development plan. Administrative staff told us that the practice was supportive of training and that they had access to protected learning (quest sessions) once a month and online training. However, we found the system in place to monitor that all staff attended regular training including refresher updates was not robust as no follow-up was undertaken when staff had not completed refresher training in line with provider requirements.

The practice was involved in the teaching of nursing students' as well medical students in their first, second and fifth years. At the time of our inspection there was one fifth year medical student. The 2013 practice assessment and visit support report showed the practice provided a very thorough and comprehensive induction for students; and had a well organised clinical programme. This report had been undertaken by the Medical Education and workforce.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found the registered provider had not protected people against the risks of inappropriate or unsafe care by means of effective operation of systems designed to assess, monitor and drive improvement in the quality and safety of the services provided.** **This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance** **How the regulation was not being met:** **The provider must have effective governance, including assurance and auditing in respect of the following areas:** • monitoring and mitigating any risks relating to cleanliness and infection control, health and safety and medicine management; • obtaining staff feedback so that they can continually evaluate the service and drive improvement and • assessing and monitoring the quality of service provision. **Regulation 17 (1)(2)(a)(b) (d)(i)(ii) (e) (f)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found the registered provider had not protected people against the risks of inappropriate or unsafe care by means of operating robust recruitment procedures, including undertaking any relevant checks.**

This section is primarily information for the provider

Compliance actions

This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and proper persons employed.

How the regulation was not being met:

The provider must have effective recruitment procedures in respect of the following areas:

- Ensure the information specified in Schedule 3, is available in relation to each such person employed and
- that DBS checks are undertaken for staff who perform chaperone duties,

Regulation 19 (1)(a)(b) (2)(a) (3)(a)