The Deepings Practice

Quality Report

Godsey Lane
Market Deeping
Peterborough
Lincolnshire
PE6 8DD
Tel: 01778 579000
Website: www.deepingspractice.co.uk

Date of inspection visit: 02 December 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Deepings Practice offers a range of primary medical services from it's surgery at Godsey Lane, Market Deeping, Lincolnshire and a branch surgery at Glinton, Cambridgeshire.

We carried out an announced inspection on 2 December 2014 as part of our new comprehensive inspection programme of the main surgery at Market Deeping.

During the inspection we spoke with patients that used the practice and met with members of the patient participation (PPG). A PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. We also reviewed comments cards that had been provided by CQC on which patients could record their views.

The overall rating for this practice is good. We found the practice to be good in the safe, effective, caring, responsive and well led domains. We found the practice was good in the care they provided to the population groups of older people, people with long term conditions, families, children and young people, working age people, people experiencing poor mental health and people in vulnerable circumstances.

Our key findings were as follows:

- The practice had robust arrangements in place to manage emergencies. Staff had received relevant training and the practice had a designated emergency room which had all the equipment required by staff in the event of an emergency. Emergency medicines were available in this room and all staff knew of their location.
- The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular meetings to discuss the care and support needs of patients and their families. GPs provided personalised cancer care by means of having their own patient list.

Summary of findings

- Patients we spoke with and comments we reviewed reflected that they received an excellent service and praised staff, describing them as friendly, having time to listen and being caring. They said staff treated them with dignity and respect.
- The practice was responsive and had implemented services which addressed the needs of not only their own patients but the wider community. They had made changes as a result of comments and feedback from patients.
- There was clear leadership with all staff being aware of their role and responsibilities. There was a strong team ethos and staff felt well supported and valued.

We saw areas of outstanding practice including:

- The Deepings Practice had responded to the needs of the wider community and provided a community based ultrasound scanning service. This meant patients of any practice could be referred to the local facility which could be more convenient than travelling to hospital and often shorten the waiting time.
- The three GP trainers have been involved in the design and implementation of a regional urgent care skills training programme for registrars. The practice now hosts simulation based clinical skills workshops.

However, there were also areas of practice where the provider needs to make improvements.

The provider should :

- Ensure that minutes of all meetings are more comprehensive and included actions and required follow up where relevant.
- Ensure policies are reviewed and updated.
- Ensure that the MHRA/drug alert policy includes further guidance for staff on what to do once they have been sent an alert to investigate.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams. The practice was using innovative and proactive methods to improve patient outcomes.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. The practice had responded to the needs of the wider community and provided a community based ultrasound scanning service.

Summary of findings

Most patients told us it was easy to get an appointment and continuity of care was provided as GPs had their own patient list. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Staff we spoke with told us they were able to recognise signs of abuse in older people and to refer those concerns to the relevant agencies. The practice hosted a leg ulcer clinic and we found the practice worked well with other agencies and healthcare providers to provide support and accessed specialist help when required.

The practice worked closely with the palliative care team as patients approached the end of their life to provide continuity of care for patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Patients told us they were happy with the care and treatment they received and felt they were involved in decisions about their care and treatment.

The practice was responsive to patients with long term conditions. People with long term conditions such as diabetes, asthma, coronary heart artery disease (CHD) were supported with health checks and medication reviews annually or sooner if required. Doctors and nurses had specific responsibilities and interests for particular long term conditions. Referrals were made appropriately, for example, diabetes, respiratory, retinopathy and podiatry, to secondary care.

There were systems in place to ensure patients were regularly monitored and provided with extensive information about the condition along with opportunities to improve their health through education, for example, diet, exercise and smoking cessation.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were above average for all standard childhood immunisations and there was a procedure for following up non-attenders. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. We were shown examples where Fraser competencies had been used when providing contraception advice. The practice had enrolled in the C-Card Scheme and all staff have been trained. This scheme enables the practice to give free contraception, for example, condoms to young people aged 13-24. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

There was a range of information available to working age patients or those who had recently retired, in the practice and on the practice website. The website provided information about self-management of minor illness for working age patients to avoid them attending the practice if this were not needed.

Women registered at the practice were routinely invited to have cervical screening tests (also called smear tests). The tests are done to prevent cervical cancer, not to diagnose cancer.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable The practice held a register of patients living vulnerable circumstances including those with dementia and learning disabilities.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations.

Summary of findings

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

The practice used a computer system called EMIS WEB which had the ability to flag patients who were vulnerable, for example, did not have a fixed address, suffered from dementia or a learning disability.

Home visits were available and these visits were predominantly reserved for people with disabilities or those who could not leave their house to attend the practice due to illness or disability.

The practice was accessible for all patients and had designated parking for people with reduced mobility.

The practice was situated in purpose built premises had an automatic front door, wide corridors, adapted toilets and hand rails in all corridors.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice worked with other services to review and share care as required with specialist teams. GPs had a personal patient list which encouraged continuity of care for patients experiencing poor mental health.

The practice had told patients experiencing poor mental health about how to access various support groups. Staff had received training on how to care for people with mental health needs and dementia.

There was a system in place to ensure regular monitoring and blood tests for patients who took certain medication related to their mental health in line with national guidance.

The practice was able to quickly access good community mental health team support through a centralised referral centre.

Summary of findings

What people who use the service say

The Deepings Practice had carried out a patient survey of 473 patients during February 2014. This showed that 92% of patients who responded said they were satisfied with how good the GP was at listening to them. This concurred with results from the national GP NHS patient survey regarding the practice, which showed that 89% of respondents said the last GP they saw or spoke to was good at listening to them.

The national survey also reflected that 88% of patients would recommend the practice to others. This figure was higher than the average for practices in the CCG.

We spoke with 16 patients on the day of our visit who on the whole were all very positive about the care and support they received at the practice.

We received nine comment cards on the day of our inspection. Most of the comments were positive. Patients felt well looked after and described staff as being friendly, having time to listen and being caring. We met with members of the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PPG member told us they had worked with the practice to address issues patients had raised.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that minutes of all meetings are more comprehensive and include actions and required follow up where relevant.
- The practice should ensure policies are reviewed and updated.
- The MHRA/drug alert policy should include further guidance for staff on what to do once they have been sent an alert to investigate.

Outstanding practice

- The Deepings Practice had responded to the needs of the wider community and provided a community based ultrasound scanning service. This meant patients of any practice could be referred to the local facility which could be more convenient than travelling to hospital and often shorten the waiting time.
- Three of the GP trainers have been involved in the design and implementation of a regional urgent care skills training programme for registrars. The practice now hosts simulation based clinical skills workshops.

The Deepings Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP, a GP practice manager, another CQC inspector and an Expert by Experience. An Expert by Experience is a person who has had experience of using this type of service and helped us to capture the views and experiences of patients.

Background to The Deepings Practice

The Deepings Practice is a GP practice which provides a range of primary medical services to around 23,000 patients from a main surgery in the town of Market Deeping in Lincolnshire and a branch surgery in Glinton, Cambridgeshire. The practice's services are commissioned by South Lincolnshire Clinical Commissioning Group (CCG). The service is provided by 11 GP partners, four salaried GPs, one senior practice nurse, seven practice nurses and six health care support workers. There is also a senior dispenser and a team of dispensing assistants. They are supported by a management team and reception and administration staff.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has two locations registered with the Care Quality Commission (CQC). We were not able to inspect the branch surgery as part of this inspection as it was registered incorrectly with the CQC as a separate location and therefore required a separate inspection. The location we inspected was The Deepings Practice, Godsey Lane, Market Deeping, Peterborough, Lincolnshire. PE6 8DD. Following our inspection the practice started the process to amend their registration with the CQC to a single location with a branch surgery.

The surgery is in a modern two storey building with a large car park which includes car parking space designated for use by people with a disability near the surgery entrance.

We reviewed information from South Lincolnshire clinical commissioning group (CCG) and Public Health England which showed that the practice population had lower deprivation levels compared to other practices within the CCG and much lower than the average for practices in England.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

Detailed findings

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

How we carried out this inspection

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

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

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain including the practice website and NHS choices.

We carried out an announced visit on 2 December 2014. During and subsequent to our visit we spoke with a range of staff including GPs, the management team, nurses, a senior dispenser and dispensary assistants as well as reception and administration staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

During our visit we spoke with representatives of the patient participation group to gain their views on the service provided by the practice.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last 12 months. Significant events were a standing item on the practice meeting agenda every six months and actions from past significant events and complaints were discussed. There was evidence from discussions with staff that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration.

Staff told us that incident forms were available either on the practice intranet or in paper format and they sent completed forms to the operations and facilities officer. They showed us the system they used to manage and monitor incidents. We tracked a sample of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

We were told that national patient safety alerts were disseminated by the operations and facilities manager and lead nurse to practice staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults.

We looked at training records which showed that all staff had received relevant role specific training to the required level on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed 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. All GPs had received safeguarding training to level three. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

GP's reported that Health Visitors informed them if a child was put on the child protection register and would also update the patient's record with a 'pop up' alert to identify to practice staff if a child was on a protection register.

One of the GP partners showed us the 'pop up' child protection alert and was able to give us an example of a case where they had been alerted by a local hospital to put a child on the child protection register and explained how they had acted promptly and appropriately to address the risk. They also told us that GPs sent written reports to child protection conferences or reviews when required.

The registrar we spoke with was aware of the practice's safeguarding policy and described how invaluable the alerts on patient records were.

There was a chaperone policy in place. Notices were visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained as a chaperone. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a

medical examination or procedure and is a witness to continuing consent of the procedure. Family members or friend may be present but they cannot act as a formal chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible by authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

The practice had purchased a dispensing robot in order to save time and reduce dispensing errors and one of the GPs told us this now meant dispensing errors were minimal. The robot is an automated dispensing system. When it receives a prescription request from the dispensary computer system, it selects and drops the required packs from the dispensary storeroom to the correct delivery point.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked anonymised patient records which confirmed that the procedure was being followed. The practice had a named phlebotomy nurse (someone who takes blood samples) who ensured patients who required regular monitoring had the correct blood tests. The GP viewed test results electronically and if concerned would flag the results straight through to the consultant looking after the patient for advice or review.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice did not handle blank prescription forms in accordance with national guidance. There was a limited system in place to track them through the practice although prescriptions were kept securely at all times. Following our inspection the business manager provided evidence showing how they had reviewed their system and introduced a robust system to ensure the security of blank prescription forms at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the key was stored securely. There were appropriate arrangements in place for the destruction of controlled drugs.

Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. The practice had Standard Operating Procedures in place which related to dispensing activities. These had been reviewed and updated in November 2014.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

Cleanliness and infection control

We observed the practice to be clean and tidy. We saw there were daily cleaning schedules in place and cleaning records were kept. The practice did not have a system in place to ensure that the cleaning schedules in place were effective. We spoke with the business manager who told us they would implement spot checks immediately.

The practice infection control lead had recently left the practice. The lead nurse had taken over this role and would be undertaking further training to enable them to provide advice on the practice infection control policy. Staff we

spoke with told us the practice areas used where kept clean and tidy. All staff received induction training about infection control specific to their role and received annual updates.

We saw evidence that an external company had carried out an infection control audit in November 2014. The practice had been proactive and taken action to raise the standard of cleaning since this audit.

Actions from this audit were identified included all cleaning equipment to be colour coded and staff made aware of their responsibilities. Hand washing signs for staff were to be made available in all clinical rooms. Both of these actions were completed at the time of the inspection but further actions were still outstanding.

Minutes of practice meetings showed that audits were discussed. The minutes did not show the findings of the audit or actions taken as a result. We spoke with the management team who told us they would ensure that future audit meetings were well minuted.

The practice had an infection control policy and supporting procedures for staff to refer to. These had been produced by an external company. The policy was comprehensive and enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were readily available for staff to use and they were able to describe how to use these to comply with the practice's infection control policy.

Each clinical room had clinical waste bins which were foot operated and lined with the correct colour coded bin liners. We saw waste was stored in an outside locked compound. However the waste bins in the locked compound were not locked. We spoke with the operations and facilities manager who told us they would ensure that the waste bins were kept locked at all times.

We saw disposable curtains were in some of the clinical rooms we looked at. These ensured that patients had privacy when being examined. Other rooms, for example, the emergency room and minor operations room had privacy screens which needed to be cleaned on a daily basis. The cleaning schedule from each room demonstrated that these had been cleaned in line with their infection prevention and control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The infection control audit carried out by an external company identified that further hand hygiene notices were needed for staff in clinical rooms.

Sharps bins were correctly assembled and labelled. We saw that the practice used a recognised coloured coded cleaning system for cleaning equipment as stated in current hygiene guidance.

The practice had blood and vomit spillage kits available for staff to use. Staff were given guidance on how to use these kits in their mandatory infection control updates.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use. Some information had not been reviewed since 2012. We spoke with the business manager who told us she would contact the external company for current updates.

We saw that the practice had a refurbishment programme for 2015 which includes the redecoration of consulting rooms and the replacement of blinds and carpets.

The practice had an up to date legionella risk assessment which had established that the building had low levels of risk in relation to legionella bacteria. The operations and facilities officer told us that they had carried out random testing of water temperatures but were in the process of putting in place a system to carry out regular checks in line with guidance.

Equipment

The practice told us that all equipment was tested and maintained regularly. The practice had made the decision to train a member of staff to test the equipment. Training had been put in place and we saw that a PAT Testing guidance protocol had been written. We looked at equipment available in the practice together with these arrangements in place which ensured equipment was serviced and safe to use. A testing plan together with frequency of testing had been implemented in line with their protocol.

Good

Are services safe?

The practice had a lift from the ground to first floor. We saw records that demonstrated that this was serviced on a regular basis. In the risk assessment the practice had identified that the fire service would attend to support the practice should the lift fail and people were trapped.

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had risk assessments in place for those staff they did not consider it necessary to carry out DBS checks for. There was a recruitment policy in place which set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records which demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the areas of the building used, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had a health and safety policy .Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were not shown any evidence that risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

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

The practice had a designated emergency room which had all the equipment required by staff in the event of an emergency. Emergency medicines were available in this room and all staff knew of their location.

All medicines were in date and checked on a monthly basis. The practice had a list of medicine expiry dates and had a procedure for replacing medicines at that time. The medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive and hypoglycaemia is deficiency of sugar (glucose) in the bloodstream.

The staff we spoke with were aware of what action to take in the event of an emergency and how they could access additional help, for example 999 services, if required.

The practice had arrangements in place to deal with emergencies. We saw a red 'business battle box' which contained it's business continuity plan. This plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Areas identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, staff contact details, practice floor plans, location of keys and contact details of a heating company to contact if the heating system failed. The business continuity plan had been reviewed in July 2014. The business manager told us they were due to meet with

Good

Are services safe?

other practices in the locality to discuss setting up a more robust set of plans to support each other in the event of an emergency. They explained how this would work particularly well as they all used the same computer system and would therefore be able to access patient records from each other's practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. A fire assembly point had been identified. On the day of the inspection the fire exits were clear. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. Nurses we spoke with told us they use NICE guidance, for example, with patients with long term conditions such as Diabetes, Asthma, Coronary Heart Disease and Chronic obstructive pulmonary disease (COPD). COPD is the preferred term for conditions which includes chronic bronchitis and emphysema. We saw that the staff received monthly updates on this guidance. GP's had access to on-line sites where NICE guidelines were demonstrated. These were used during consultations.

Chronic disease management clinics were undertaken by nursing staff and clear management was in place for follow up with GP's if there was any question that a patient's condition was deteriorating.

The GP who had responsibility for diabetes management had produced guidance for type two diabetes management for the diabetes nurse specialist to use in clinic. We saw this had clear guidance on medication steps and was fully referenced.

The practice held a same day urinary tract infection (UTI) clinic which was run by the practice nurses. One of the GP partners had produced a template for the nurses to use following Health Protection Agency (HPA) guidelines for UTI acute management and follow up. There were effective follow up plans in place if for example if blood was noted in the urine sample this would prompt checks for underlying diseases.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

One of the GPs at the practice had also completed a review of the provision of care for atrial fibrillation (AF) and heart failure across local practices and as a result had attempted to opportunistically screen patients for AF when they attended for a flu vaccination. Atrial fibrillation is the most common type of arrhythmia, which is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm.

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

One GP had noticed that dermatology referrals were high so had arranged some in-house training to assist in more appropriate referrals being made.

We received information of concern prior to our inspection from a patient who felt that a diagnosis had been delayed as their referral was not made early enough despite age and family history considerations. We raised this with two of the GP partners and they confirmed they were already aware of the incident and were treating it as a significant event.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

We looked at clinical audits that had been undertaken in the last year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. A GP had recognised an example of inappropriate patient care and raised it, the practice had responded promptly by means of an audit and the results were acted on with reference to consultant advice. The results were then disseminated and a procedure put in place to protect patients in future. Other examples included audits on NICE guidance regarding a diabetes drug and an audit on urinary tract infections in children.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a system used to monitor the quality of services in GP practices. QOF consisted of groups of indicators against which practices score points according to their level of achievement. The practice had performed well in QOF and met all the minimum standards for QOF in diabetes,

Good

Are services effective?

(for example, treatment is effective)

asthma, chronic obstructive pulmonary disease (lung disease) and relating to mental health. This practice was not an outlier for any QOF (or other national) clinical targets.

We looked at General Practice Outcome Standards (GPOS) data from NHS England and saw that most of the practice value indicators were significantly better than the CCG or national values. The Deepings practice was noted as a higher achieving practice.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

We saw some evidence of clinical audits being discussed at practice meetings but it was not clear how findings would be disseminated to all GPs or other clinical staff who were not at the meeting. Neither was it apparent how the audit results altered practice or showed improvement in patient care as not all audits were shown to have completed the audit cycle.

The practice had a named GP as prescribing lead. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. One GP we spoke with told us he had audited his own antibiotic prescribing over two time periods and shown a decrease in prescriptions given.

GP's were able to review regular medication lists for all their patients and changed the frequency of medication review as they considered appropriate in line with the patient's individual needs.

The practice had achieved and 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. The practice had achieved 100% for the QOF palliative care indicator. GPs provided personalised cancer care by means of having their own patient list. They made special provision for cancer patients and told us they would always see them or call them when required. GPs we spoke with described a good rapport with district nurses which gave good continuity of care for end of life patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example one member of the dispensary staff we spoke with told us they had been offered the opportunity to take further qualifications in dispensing despite the fact it was not a requirement for the tasks they were undertaking.

As the practice was a training practice, doctors who were training to be qualified as GPs were enabled to offer patients extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. The practice had between two and four registrars at a time. We spoke with one registrar who felt well supported and described how the training rooms were in the same corridor as their GP trainer so they felt able to call the GP trainer easily during a consultation if they required support. They had regular debriefs after each surgery.

Training rooms had cameras in them so that trainees could record their consultations for training purposes with the patients' permission. Trainer GPs were able to view the trainee consultation as it took place in real time on a screen in the Trainers Office. This was invaluable for trainee support and reviewing their consultation technique.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in administration of influenza vaccines and cervical screening.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures in place for relevant staff to pass on, read and action any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by GPs, district nurses, social workers and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information and coordinating care. Decisions about care planning were documented in a shared care record. We looked at minutes from these meetings and found that they did not contain sufficient information to demonstrate what had been discussed or the actions taken. We spoke to a GP who told us they would ensure that future meetings were minuted appropriately. We spoke with other healthcare providers who spoke positively about their working relationship with the practice. They were based at the practice and felt part of the practice team. They were invited to practice meetings and could speak to a GP if they had a problem even during surgery times.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS Web to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, for example with making do not attempt resuscitation orders(DNAR) we saw an example where a DNAR alert came up immediately when the patients notes were selected.

Nursing staff we spoke with were able to demonstrate a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to a medical examination and treatment).

The practice was enrolled in the C-Card Scheme. This scheme enabled the practice to give free contraception, such as condoms to young people aged 13-24. All the practice nurses were trained to support this scheme. Fraser guidelines were used for each young person who attended and used the C-Card scheme.

The practice had a consent policy. However this had not been reviewed since February 2012. We were told by the lead nurse that consent training was mandatory. Health care support workers received more training as they supported the GPs with minor operations. We spoke with the business manager who told us the practice would ensure that this policy was reviewed and updated.

Good

Are services effective?

(for example, treatment is effective)

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint and were able to describe an incident with a potentially violent patient and how they had dealt with it appropriately. The practice had a violent behaviour policy in place which was also available on their website.

Health promotion and prevention

It was practice policy to offer a health check with a practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40-75. The uptake for the healthcheck was much higher than the average for the CCG and nationally. A GP showed us the template they used to follow up patients who had been identified by the healthcheck as having risk factors for disease.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. GPs confirmed that they offered longer appointments to those with a learning disability. The business manager told us the practice had recently signed up to the learning disabilities health check scheme enhanced service (ES) and told us they were due to start to perform the relevant health checks.

We saw evidence of opportunistic screening. For example when women attend for contraception, the template which was used reminded the clinician to record smoking status and offer support with smoking cessation as appropriate. There were also screen pop ups on the practice computer system to remind GPs to offer chlamydia screening to young people.

The practice's performance for cervical smear uptake was 86.3%, which was better than others in the CCG area. We reviewed cervical smear data with one of the GPs and saw that the percentage of nadequate smears was lower than average.

The GPs all had personal patient lists which meant that all patients had a named GP responsible for their continuity of care. There were a number of care homes served by the practice and because the GPs held personal lists this meant two or more GPs could visit the same care home on the same day to see different patients. The practice considered that although this could be seen to be an ineffective use of time it was outweighed by the increased continuity of care for patients and their families.

The practice signposted patients to various support groups such as Addaction and Drug and Alcohol Recovery Team (DART).

The GPs we spoke with told us they were able to access good community mental health team support through a centralised referral centre and patients could be seen within 24 hours.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Their performance for all immunisations was above average for the CCG, and there was a procedure for following up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 343 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above the CCG average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time. Also 83% of practice respondents said the last nurse they saw treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were polite, caring and efficient. They said staff treated them with dignity and compassion. Two comments were less positive but there were no common themes to these. We also spoke with 16 patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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 business manager. The business manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We were told by staff members that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. Both these results were similar to the average for the CCG. The results from the practice's own satisfaction survey showed that 88% of patients said they were sufficiently involved in making decisions about their care.

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

Patient/carer support to cope emotionally with care and treatment

Comments from patients reflected that they were positive about the emotional support provided by the practice. They confirmed that they received help to access support services to help them manage their treatment and care when it had been needed.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice had noticeboards which had a wide variety of information. The

Good

Are services caring?

practice's computer system alerted GPs if a patient was also a carer. Information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP would be informed and the GP would then make contact with the family either by telephone or letter and visit if appropriate. Signposting to bereavement support agencies was also offered. We saw cards from relatives who had been bereaved thanking the practice for their support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The Deepings Practice had responded to the needs of the wider community and provided a community based ultrasound scanning service. This meant patients of any practice could be referred to the local facility which could be more convenient than travelling to hospital and often shorten the waiting time. Because of this the practice had been nominated for The General Practice Awards in 2013 in the innovators of the year category and been a finalist.

Telephone access had been identified as a problem for patients and in response the practice had installed more telephone lines and introduced a message which updated patients when they rang the practice as to where they were in the queue to have their call answered. The business manager told us they had received positive comments from patients regarding shorter waiting times following this. The practice had a dedicated telephone line for health professionals.

Data showed that the practice had a higher than expected number of emergency admissions. The practice was aware of this and had responded by making changes to its appointment provision. The practice had increased the amount of urgent appointments in the afternoon by having two GPs on call which meant more appointments were available until 6pm.

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). We looked at minutes of PPG meetings which reflected actions to be taken to improve the service for patients following issues identified in the practice's annual patient survey. These included new signage for the practice and promoting the use of text messages as a means of communication with patients.

Lack of car parking had been highlighted as a problem for patients. The practice had addressed this by spreading appointments through the day to alleviate bottlenecks at certain times of the day. They had also increased the staff car park to provide more spaces for patients in the main car park and had plans in place to extend the main car park.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed equality and diversity training.

The practice PPG operated a voluntary car scheme to provide transport to medical appointments primarily for the elderly or disabled and patients without access to public or private transport which patients found invaluable.

We asked GPs how they supported travellers if they attended the practice. We were told that only a few travellers used the practice but when they did they were given treatment the same as anyone who walked in to the practice regardless of their situation. The practice had access to online and telephone translation services and one of the GPs was trained in the use of sign language.

A comment card we received from one patient described how they had been on long- term sick leave and how they had been actively supported by one of the GPs in their longer term goal to return to work.

The premises and services had been adapted to meet the needs of people with disabilities. There were automatic doors for patients with reduced mobility. The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. The practice had wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open from 8am to 6.30pm on weekdays and appointments were available from 8.30am to 6pm on weekdays. The practice also offered extended hours and pre bookable appointments were available on Saturday mornings with a GP or nurse between 8am and 11.00am at the Glinton branch surgery. The appointment system offered a mixture of pre-bookable appointments for patients who wished to see their own GP which could be made up to 6 weeks in advance. Same-day appointments were also available.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website which was easy to do. There were text message reminders for appointments and patients were offered telephone consultations where appropriate. The practice had started to offer appointments with GPs via the online service which were bookable four to six weeks in advance. They told us this had improved patient satisfaction as it took pressure off the number of incoming telephone calls.

We saw how staff were able to highlight via the practice computer system, if they considered a GP needed to see a patient urgently during a surgery. GPs were able to flexibly prioritise their patient list, for example a young child with symptoms of rash and temperature.

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

Longer appointments were available for people who needed them. Home visits were made to local care homes as required by the patient's named GP and to other patients who needed one, including those with long term conditions and older people.

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

The practice's extended opening hours were particularly useful to patients with work commitments. This was confirmed by comments received from patients. Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people.

We saw that the practice used 'pop ups' on patient records to highlight accessibility to GPs. This identified to the receptionists, for example, which GP to book a terminal cancer patient in with to ensure continuity of care at any time.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice complaints procedure was available in the patient waiting area and on the practice website. At the time of our inspection the practice had a clearly defined complaints procedure but a complaints policy was not available. Following our inspection the business manager provided us with the practice complaints policy. The complaints procedure gave guidelines to patients as to how to raise a complaint and what they could expect from the practice in response to a complaint. There were details of advocacy support available for help with raising a complaint and details for the Clinical Commissioning Group and the Health Service Ombudsman for patients to contact if they were not satisfied with the outcome of their complaint to the practice.

There had been 28 written or verbal complaints received by the practice in the last 12 months. We looked at three of these and saw they had been dealt with appropriately and were responded to in a timely manner. The complaints had been reviewed and details of actions recorded. The operations and facilities officer was able to describe how lessons learned from individual complaints had been acted on. For example, they told us that as a result of one of the complaints we looked at, an alert had been added to the patient's records to avoid a reoccurrence of the reason for their complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice discussed complaints twice a year as part of their regular practice meeting and we saw that the minutes from the most recent meeting reflected that a selection of complaints had been discussed. However it was not clear from the meeting minutes or the complaints log how learning points from complaints had been discussed with staff or when changes in practice or procedure had been implemented as a result of a complaint. The operations and facilities officer told us they would update the log to reflect learning and changes in practice and use this to identify themes or trends. They provided us with evidence of this following our visit.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and forward planning. These values were clearly displayed on the practice website and available in the waiting area. The practice vision and values included providing an efficient, academically sound and compassionate service to the sick and to promote good health practices within the community.

The practice had plans in place to widen the scope of their ultrasound scanning, for example to enable them to also scan shoulders and hips. They also intended to increase the range of minor surgery they offered. Each time there had been a need, the practice had developed their premises, for example, in order to support training.

The staff members we spoke with were engaged with the practice vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these could be accesses by staff via the practice intranet. We looked at 13 policies. Two out of the 13 policies we looked at had not been reviewed in the previous 12 months.

There was a clear leadership structure with a well identified senior management team in place with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. Each partner had clear management responsibilities and was also responsible for a range of enhanced services.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards and each partner was responsible for an area of QOF.

Staff we spoke with told us they felt part of a team, were well supported, their views were listened to and they knew who to go to in the practice if they had any concerns.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we looked at an audit which related to prescribing and as a result of the audit patients had been reviewed and medication altered. The practice had responded to prevent future misprescribing by putting 'pop ups' in place every time the medication was prescribed to alert GPs as to whether it was the correct procedure.

The practice had arrangements for identifying, recording and managing risks. We saw that risk assessments had been carried out. Where risks had been identified an action plan had been produced and was in the process of being implemented at the time of the inspection. For example in relation to fire safety and manual handling.

The practice held monthly governance meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or informally outside of meetings.

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example consent, waste management, chaperone and infection control which were in place to support staff. Two of the policies we looked at were out of date. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, suggestions and complaints received. The practice had introduced the NHS friends and family test (FFT) which became into effect on 1 December 2014. The FFT is an opportunity for patients to provide feedback on the care and treatment they receive with a view to improving services. This had been publicised in the practice and on their website and patients were able to give feedback via the website if they wished. We looked at the results of the annual patient survey and 69% of patients had expressed difficulty in accessing the practice by telephone. We saw as a result of this the practice had

Are services well-led?

Good

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

installed extra telephone lines and also patients were now advised of their position in the queue while waiting for their call to be answered. The business manager told us they had received positive comments from patients regarding shorter waiting times following this.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. The PPG had been involved in the practice annual surveys and met every six to eight weeks. We discussed the analysis of the last patient survey with two members of the PPG who told us it was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff surveys, away days and generally through staff meetings, appraisals and day to day interactions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had highlighted an area of practice they did felt less confident in and had received specific training to address this. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy available for staff to refer to. We spoke with a member of staff who was aware of whistleblowing and relevant procedures and there was also reference to whistleblowing in the staff handbook.

Management lead through learning and improvement

The nursing staff told us that the practice fully supported them to maintain their clinical professional development through training and mentoring.

We looked at nine staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days.

The practice closed for an afternoon every two months with a range of clinical issues discussed which was confirmed by meeting minutes we viewed. External consultants were sometimes asked to attend regarding a specific clinical topic.

The practice was a GP training practice. Registrars were supported with regular debriefs and tutorials.

They also had the opportunity to visit other training practices for tutorials and for trainees from other practices to visit the Deepings practice to benefit from their services.

The GP trainers had been involved in the design and implementation of a regional urgent care skills training programme for registrars. The practice now hosts simulation based clinical skills workshops and intends to widen this to include a nurse simulation skills programme which would also be available to nursing staff from other practices.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings every six months or sooner if required to ensure the practice improved outcomes for patients. For example we saw evidence where as a result of a significant event the process for confirming information from callers was reviewed.