Belvoir Health Group

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Belvoir Health Group on 12 February 2015. This is the first time we have inspected this practice.

Overall the practice is rated as good. Specifically, we found the practice good for providing safe, effective, caring, responsive and well-led services. It was also rated as good for providing services for all the population groups.

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

- Comments from patients were generally very positive about the care and services they received. They said that they were treated with kindness, dignity and respect and were involved in decisions about their care and treatment.
- The practice was accessible and well equipped to meet patients' needs.
- Patients were able to access care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day.
- Procedures were in place to help keep patients safe and to protect them from harm.
- Patients felt listened to and able to raise concerns about the practice. Concerns were acted on to improve the service.
- Staff felt valued and well supported. The practice had a motivated and established staff team, with appropriate knowledge and skills to enable them to carry out their work effectively.
- Systems were in place to assess and review information about the quality and safety of services that people received, although the clinical audit programme required developing to further improve outcomes for patients.
- The skill mix and leadership had been strengthened by appointing a team leader for the three branch locations, a nurse manager to lead the nursing team and a second operations manager. The new posts helped to drive improvements and ensure the services were well-led.

Summary of findings

- The practice obtained and acted on patients views. The Patient Participation Group (PPG) worked in partnership with the practice to improve the services for patients.

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

Importantly the provider should:

- Further develop the clinical audit programme linked to medicines management information, safety alerts and significant events to improve outcomes for patients.
- Provide further opportunities for nurses and GPs to share knowledge and learning, and work together as a team to ensure a consistent and effective approach to meeting patients' needs.
- Ensure that information available to patients enables them to understand the complaints process.

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. Arrangements were in place to ensure that the practice was clean, safe and adequately maintained. Systems were also in place to keep patients safe and to protect them from harm. Risks to patients were assessed and appropriately managed. The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Learning took place and appropriate action was taken to minimise incidents and risks. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice had a motivated staff team with appropriate knowledge and skills to carry out their work. Staff received appropriate training. An improved appraisal system was being put in place to support staff development.

Staff worked closely with other providers to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. There were limited opportunities for nurses and GPs to share clinical knowledge and best practice as regular joint meetings were not held. However, three monthly clinical governance meetings had recently been introduced, which involved the GPs and nurse manager. Clinical audits were completed to determine that patients received appropriate care and treatment, although the audit programme required developing to further improve outcomes from patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients described the staff as friendly and caring, and said they were treated with dignity and respect. Patients were involved in decisions about their care and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and conditions. We observed that patients' privacy, dignity and confidentially were maintained; staff were respectful and polite when dealing with patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.Patients told us that the practice was responsive to their needs. The services were flexible and were planned and delivered in

Summary of findings

a way that met the needs of the local population. Patients were able to access care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day. There was a culture of openness and people were encouraged to raise concerns. Patients' concerns and complaints were listened to and acted on to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice obtained and acted on patients' views to improve the service. The practice had a clear vision to deliver high quality care and services for patients, which was shared by the staff team. Systems were in place to assess and review information about the quality and safety of services that people received.

The skill mix and leadership had been strengthened by the appointment of a team leader for the three branch locations, a nurse manager to lead the nursing team and a second operations manager. These were new posts to help drive improvements and ensure the services were well-led. Staff said that they felt valued, well supported, and generally involved in decisions about the practice. The culture of the organisation was open, and staff felt able to raise any issues with senior staff as they were approachable.

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. Patients over 75 years were invited to attend an annual health check, and had a named GP to ensure their needs were being met. The practice worked closely with other services to enable patients to remain at home, where possible. The practice was signed up to an enhanced service to avoid unplanned admissions into hospital, and had identified older patients who were at risk of admissions. Care plans had been developed for such patients, which were kept under review.

A hearing loop system was available to support patients who used hearing aids. The practice was signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated. To date, 82 % of patients over 65 years of age had received an influenza immunisation to reduce the risk of them developing flu in the 2014/2015 period. Home visits were offered and the dispensary provided a home delivery service, including the provision of compliance aids to assist patients to take their medicines correctly. Carers were identified and supported to care for older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients were offered an annual health review including a review of their medicines. They also had an allocated GP to ensure their needs were being met. When needed, longer appointments and home visits were available. Patients' with long term conditions and other needs were reviewed at a single appointment where possible, rather than having to attend various reviews. The practice kept a register of patients with complex needs requiring additional support, and worked with relevant professionals to meet their need. Patients were educated and supported to self-manage their conditions. Clinical staff had lead roles in the management of long-term conditions, having received appropriate training.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Priority was given to appointment requests for babies and young children. Systems were in place for identifying and following-up children at risk and living in disadvantaged circumstances. The practice worked in partnership with midwives, health visitors and school nurses to meet patients' needs.

Summary of findings

Immunisation rates were high for all standard childhood immunisations. Children were able to attend weekend appointments outside of school hours. The practice provided maternity care and family planning services. The practice also provided advice on sexual health for teenagers, and screening for sexually transmitted infections.

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). Patients were offered telephone consultations and were able to book non-urgent appointments around their working day by telephone or on line. Patients were also able to access appointments at weekends. The practice offered a 'choose and book' service for patients referred to secondary services. This provided greater flexibility over when and where their test took place, and enabled patients to book their own appointments. NHS health checks were offered to patients aged 40 to 74 years, which included essential health checks and screening for certain conditions. The practice also offered health promotion and screening appropriate to the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients were offered extended or same day appointments or telephone consultations. Vulnerable patients were invited to attend an annual health review, and had an allocated GP to ensure their needs were being met. The practice worked with relevant services in the case management of vulnerable people, to ensure they received appropriate care and support. When needed, longer appointments and home visits were available. Carers were identified and offered support, including signposting them to external agencies.

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 held a register of patients experiencing poor mental health. Patients were offered extended or same day appointments or telephone consultations. Counselling services were held at the practice. Patients were invited to attend an annual health review, and had an allocated GP to ensure their needs were being met. The practice worked with mental health services to ensure that appropriate risk assessments and care plans were in place, and that patients' needs

were regularly reviewed. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. The practice was signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated.

Summary of findings

What people who use the service say

Prior to the inspection, we received comment cards from 30 patients. These were mostly very positive about the care and services they received. Common themes were that patients were treated with dignity and respect, and that the staff were caring and helpful. Patients also praised the care and treatment they received. All patients with the exception of one described their experience of making an urgent and non-urgent appointment as good, with urgent appointments usually available the same day.

During our inspection we spoke with three patients. They told us they were satisfied with the care and services they received. They also said that they felt listened to and were involved in decisions about their care and treatment.

The practice obtained patients' views to improve the service. The practice had a Patient Participation Group (PPG). The PPG are 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 and the PPG issued an annual satisfaction survey to patients attending all three surgeries. The results of the March 2014 survey generally showed that patients were satisfied with the care and services they received. We spoke with a member of the PPG. They told us that they had agreed the action points from the last survey, and that the practice staff worked with them to improve the service.

We looked at the national patient survey data which was published in January 2015. The survey was sent out to 259 patients, of which 121 responded. The data showed that the practice performed above the local CCG average in the following areas: 92% said the last time they saw a GP they were good or very good at involving them in decisions about their care and treatment, 96% said that they were good or very good at explaining tests or treatment and 97% said that they were good at treating them with care and concern.

The practice scored below the local CCG average in the following areas: 46% said they usually waited 15 minutes or less after their appointment time to be seen, 83% said the last time they saw a nurse they were good at giving them enough time and 87% said they were good at treating them with care and concern. The staff were aware and had taken action to address these issues, including changes to the staffing structures and how the clinics were run to benefit patients.

We also reviewed the patient reviews of the practice on NHS Choices completed in the last 12 months. All three comments were very positive about the care and treatment patients received.

Areas for improvement

Action the service SHOULD take to improve

- Further develop the clinical audit programme linked to medicines management information, safety alerts and significant events to improve outcomes for patients.
- Provide further opportunities for nurses and GPs to share knowledge and learning, and work together as a team to ensure a consistent and effective approach to meeting patients' needs.
- Ensure that information available to patients enables them to understand the complaints process.

Belvoir Health Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a practice manager and an inspection manager.

Background to Belvoir Health Group

Belvoir Health Group is a partnership between twelve GP partners operating from three branch surgeries in the South Nottinghamshire area. The main branch of the practice is situated in Cropwell Bishop, with two other branches located at; Bingham Medical Centre, Newgate Street, Bingham, NG13 8FD and The Surgery, Cotgrave Health Centre, Candleby Lane, Cotgrave, NG12 3JG.

There is a single patient list across the three branches of approximately 23,700 with an increasing number of patients registering at the practice. Patients can ask for an appointment at any of the three branches as there is a shared clinical system. This offers patients a high degree of flexibility.

The main branch serves a relatively affluent, rural population and the average life expectancy for men and women is above the national average. The practice list has 57% of patients aged 45 years and over, which is above the national average.

There are twelve partners and four salaried GPs working at each of the specific branches. There are 103 GP sessions, 37 nursing sessions and 26 sessions with a healthcare assistant available each week across the three branches. There are nine female and seven male GPs offering patients a choice of gender of their GP.

The GPs are supported by a team of six practice nurses, a practice nurse manager (who is an advanced nurse practitioner), four healthcare assistants, two phlebotomists, nine dispensary staff and 23 administrative and reception staff. In addition the management team includes a business manager, two operations managers, three team leaders and a financial administrator.

Belvoir Health Group is registered to provide the following regulated activities: Diagnostic and Screening Procedures, Treatment of Disease, Disorder or Injury, Surgical procedures, Maternity & Midwifery & Family Planning.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services.

The practice have opted out of providing out-of-hours services to their own patients, although they are signed up (along with all other practices in the CCG) to provide urgent weekend appointments with a GP from a local location. This is part of the Prime Minister's Challenge Fund to improve patient access. At all other times patients can contact the out of hours service outside of practice opening hours, which is provided by NEMS Community Benefit Services.

Belvoir Health Group offers placements for second and fifth year medical students.

Why we carried out this inspection

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

Detailed findings

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.

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
- 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 information about the practice and asked other organisations (including the CCG, NHS England area team, Healthwatch, the local medical committee and the overview and scrutiny committee of the local authority) to share what they knew about the service.

We carried out an announced comprehensive inspection of this practice on 12 February 2015.

During our visit we spoke with a range of staff including the business manager, operations manager, team leader, nurse manager, practice nurse, healthcare assistant, four GPs, reception and clerical staff. We also spoke with a district nurse and the primary care pharmacist.

We received comment cards from patients, and spoke with three patients and a member of the Patient Participation Group (PPG). The PPG are 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.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example there had been an incident involving a needle stick injury. Action had been taken to protect the health and wellbeing of the member of staff, and measures were put in place to prevent the incident from re-occurring. This was shared with all staff to ensure learning took place across the practice.

We reviewed safety records, incident reports and minutes of meetings for the last two years. These showed the practice had managed these consistently over time and so could show evidence of a safe track record. A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. Records showed that safety incidents and concerns were appropriately dealt with.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. A policy set various events considered to be a significant event. For example, a delayed diagnosis, prescribing error or a complaint.

We reviewed records of significant events that had occurred during the last two years. These showed that the practice had followed the policy, and were reviewing events in line with this. There was evidence that appropriate learning and improvements had taken place and that the findings were shared with staff at team meetings. For example, following an incident involving a patient the practice had put more robust back-up systems in place to ensure they always had a sufficient quantity of emergency equipment.

We reviewed an incident involving a patient's death, which was not considered a significant event under the practice's policy. It was therefore not recorded or followed up as an event. However, senior managers agreed to review this as a significant event, to consider what lessons could be learnt and improvements made to the quality of patients care. They also agreed to review the criteria set out in the significant events policy to ensure this covered all critical incidents.

Staff told us that the practice was open and transparent when things went wrong, and that patients received an apology when mistakes occurred. We saw that an annual review of all significant events across the three branches was completed. Senior staff told us that they considered any trends and patterns and if there had been changes or improvements year on year. However the records we reviewed did not clearly show this. Senior managers agreed to include this information in future reviews.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received recent safeguarding training specific to their role. For example, the GPs had completed level three children's training and relevant vulnerable adults training. Records we looked at showed that staff had received appropriate training.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and who to speak to in the practice if they had a safeguarding concern. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Contact details were accessible.

A system was in place to highlight vulnerable patients on the practice's electronic records, including children and young people on a child protection plan. The alert system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when a patient or their next of kin attended appointments or contacted the practice.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. The lead for safeguarding was aware of vulnerable children and adults registered with the practice.

Records showed good liaison with partner agencies such as the police and social services to share essential information about vulnerable patients. Essential information was recorded in patient's records.

Good

Are services safe?

All staff we spoke with were aware of the safeguarding lead and who to speak with if they had a safeguarding concern.

Records showed that monthly meetings were held with relevant professionals, to share information and discuss children and adults who were considered to be at risk of harm or abuse across the three branches. The children's meetings were attended by GPs, the health visitor, midwife and school nurses. The adults meetings were attended by the GPs, community matron, district and specialist nurses.

Staff told us that the member of staff who delivered patients medicines to their home would raise any concerns about a vulnerable patient's wellbeing, with the practice team to ensure their welfare. This acted as a safety net for patients who did not, or could not leave their houses.

Patients' individual records were managed in a way to keep people safe. Records were kept on the EMIS electronic system, which held all information about the patient.

There was a chaperone policy, which was visible to patients attending the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional, during a medical examination or procedure).

Records we looked at supported that the nursing staff had been trained to be a chaperone. The health care assistants were due to attend relevant training on 20 February 2015, to enable them to carry out chaperone duties. Nursing staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Arrangements were in place to ensure that medicines were managed safely and appropriately. We found that medicines were stored securely.

Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, the IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Regular checks were carried out to ensure that medicines were within their expiry date and appropriate for use. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations.

A policy was in place 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. Stock rotation systems were in place to ensure vaccines were within their expiry date and suitable for use.

The nurses and the health care assistant administered vaccines using patient group directions (PGD) in line with national guidance and requirements. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw evidence to confirm that the nurses and the health care assistant had received appropriate training to administer vaccines.

The policy on repeat prescribing was available to staff. The practice had established a service for patients to pick up their dispensed prescriptions at two of the surgery branches, and had systems in place to monitor how these medicines were collected.

Patients who received repeat prescriptions told us the system for obtaining their medicines, worked well to enable them to obtain further supplies of essential medicines.

The main practice branch was a dispensing practice for patients who lived in the Cropwell Bishop area. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

Dispensing staff at the practice were aware that prescriptions should be signed by a GP before being dispensed. If prescriptions were not signed before they were dispensed they would send it back to the GP. We saw that this process was working in practice.

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.

We found that blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

A system was in place for the management of high risk medicines, which included regular monitoring in line with

national guidance. The practice worked with the Clinical Commissioning Group (CCG) medicines team, and carried out regular checks to ensure that patients' medicines were managed appropriately.

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

There were arrangements in place for the destruction of controlled drugs. Regular audits of controlled drug prescribing were carried out to look for unusual products, quantities and doses. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Comment cards from patients and those we spoke with told us the practice was always clean, and they had no concerns about the standards of hygiene and cleanliness.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to apply infection control measures. The practice had a lead for infection control who had undertaken relevant training to enable them to advise staff on the policy.

All staff received induction training about infection control specific to their role and an annual update. Staff we spoke with confirmed they had received the training. They also had access to the policy and procedures to enable them to apply infection control measures. For example, personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use.

Clinical staff had a cleaning schedule, which they were responsible for. The schedule was supported by a checklist, indicating what equipment needed to be cleaned and how often. The records we saw were up to date and fully completed.

Records also showed that clinical staff checked the stock supplies of clinical and medical devices at regular intervals, to ensure they were in date, and sealed where required. Various supplies we checked including dressings, syringes and equipment used for minor surgery were in date and sealed.

Staff told us of various improvements that had been made to the premises to meet infection control standards. This included new soap dispensers, sinks, mixer taps and disposable curtains in the consultation rooms.

We were shown a new infection control audit, which was comprehensive. This was completed in January 2015 across the three branch sites to review consistency in practice. The findings and any remedial actions were shared with the staff team. The report showed high levels of compliance, and that various remedial actions had been completed. The infection control lead agreed to ensure that the remedial actions that had yet to be completed included timescales for completion. The new audit would be completed annually to monitor improvements relating to infection control.

A policy was in place for ensuring that staff were protected against the risks of acquiring Hepatitis B, which could be acquired through their work. All staff were offered Hepatitis B immunisation, which was undertaken by the occupational health staff. Senior managers acknowledged that the records required updating to show that all staff were up to date with their vaccination and protected from Hepatitis B infection. The practice were taking steps to address this.

The practice had a policy for the testing and management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records showed that an external company was carrying out required control measures and regular checks in line with the practice's policy to reduce the risk of legionella infection to staff and patients.

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. A schedule of testing was in place. We saw evidence of

calibration of relevant equipment; for example the electrocardiogram (ECG), weighing scales and the blood pressure measuring devices had all been calibrated in July 2014.

Staffing and recruitment

The practice had a recruitment policy that largely set out the standards it followed when recruiting new staff. The practice manager agreed to update the policy to detail all stages of the process and information required by law.

We looked at three files of staff recently employed who worked in different roles within the practice. We found that robust recruitment procedures were generally followed in practice to ensure that new staff were suitable to carry out the work they were employed to do. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

One file we checked did not contain details of references obtained to ensure the person was suitable to work with vulnerable adults and children. Following the inspection, we received a copy of the references, which were satisfactory..

Staff we spoke with assured us that they were formally interviewed prior to being offered a position to work at the practice. However, the files we looked at did not contain a record of the interviews carried out. This did not demonstrate that robust and fair procedures were followed. The business manager confirmed that a standard interview form was not used to support the decision making process. They agreed to address this issue with senior managers.

A policy for checking nurses and GPs qualifications and registration to practice was in place. Records showed that a robust system was in place for ensuring all clinicians remained registered to practice with their professional bodies, in line with the policy.

The practice had a low turnover of staff. Various staff had worked at the practice for a number of years, which ensured continuity of care and services.

Staff told us about the arrangements for ensuring sufficient numbers and skill mix of staff were available to meet patients' needs. They covered each other's absences to ensure enough staff were available. There said that there were usually enough staff on duty to maintain the smooth running of the practice, and there were always enough staff to keep patients safe. The nursing cover was being re-organised to ensure sufficient cover across the three branches.

We saw there was a rota system in place for the different staff groups to ensure that enough staff were on duty. Records showed that the staffing levels and skill mix were in line with planned requirements.

Monitoring safety and responding to risk

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

Records showed that all equipment was regularly tested and maintained to ensure it was safe to use. Arrangements were also in place to ensure that the premises were appropriately maintained and safe.

The practice had a health and safety policy, which staff had access to. There was also a health and safety representative. We saw that the practice had completed various health and safety risk assessments, including actions required to reduce and manage the risks.

A quarterly health and safety meetings were held covering all three branches. The minutes of meetings showed that a wide range of health and safety issues were discussed and acted on at the meetings.

We saw that staff were able to identify and respond to risks to patients including deterioration in their well-being. For example, procedures were in place to deal with patients that experienced a sudden deterioration in health, and for identifying acutely ill children to ensure they were seen urgently. Arrangements were also in place for patients experiencing a mental health crisis, to enable them to access urgent care and treatment. The practice monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received

Good

Are services safe?

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 notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient, and that the practice had learned from this and purchased additional equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Actions were recorded to reduce and manage the various risks. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that health and safety checks had been carried out at the required intervals. Records showed that most staff were up to date with fire training or were booked to attend this, and had practised regular fire drills to ensure they knew what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us they received effective care and treatment. Where patients had needed to be referred to a hospital or community services, the referral was promptly sent.

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 (NICE) and from local commissioners on line.

There were limited opportunities for nurses and GPs to discuss new guidelines and agree changes to practice, as regular joint meetings were not held. However, three monthly clinical governance meetings had recently been introduced out of the need to improve the sharing of clinical knowledge and learning. They involved all partners and salaried GPs, and the nurse manager.

From our discussions with the GPs and nurses we found that improvements were needed to ensure that all clinicians worked together to ensure a consistent approach to meeting patients' needs in the most effective way. The senior managers acknowledged this was an area for improvement.

The clinical staff were lead in clinical areas such as diabetes, heart disease and respiratory conditions including asthma, which allowed the practice to focus on specific conditions. A nurse manager had recently been appointed to manage the nursing staff across the three branches, which will bring about consistency in practice. The nursing team was being re-organised and supported to develop their skills, and enable them to effectively manage patients with long term conditions.

There was a holistic approach to meeting patients' needs. The practice had an established staff team who knew their patient groups well. The GPs had oversight and a good understanding of best treatment for each patient's needs. They worked closely with local services and other providers to meet patients' diverse needs. The GPs and nurses completed thorough assessments of patients' needs, and provided care and treatment in line with NICE guidelines.

We found that patients were referred appropriately to other services on the basis of need. However, we noted that one patient had complained that they had not been referred promptly to a specialist following the diagnosis of a painful condition. The reason for this had been investigated and addressed to prevent further incidents.

National data showed that the practice was in line with referral rates to secondary and other community care services. GPs we spoke with used the two week national standards for referring patients with suspected cancers. We saw minutes from meetings where reviews of elective and urgent referrals were made, to determine if there were any actions they needed to take to improve.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included, infection control, medicines management as well as QOF (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).

The QOF performance data for 2013 to 2014 showed that the practice achieved a total of 99.9%, scoring above the national and local average in all clinical areas assessed. This practice was not an outlier for any QOF or other national clinical targets.

The practice also 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. This benchmarking data showed the practice had outcomes that were comparable or better to other services in the area.

We were shown two clinical audits that had been undertaken in the last 12 months; both were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one clinical audit focussed on foot care in regards to patients with diabetes. The initial audit results showed that 72% patients had had their feet assessed and classified in terms of risk of complications. The re-audit data showed that 94% patients had had their feet assessed and classified in terms of risk. In addition, seven out of nine of the high risk patients had been referred on to specialist foot services, which was an improvement to the initial data. Changes were made following the audits to ensure that all patients were appropriately assessed and referred, where required.

Good

Are services effective?

(for example, treatment is effective)

The GP partners assured us that further audits had been completed across the other two branches. They acknowledged the need to develop the audit programme linked to medicines management information, safety alerts and significant events, given the large size of the practice and clinical team covering the three branches. The clinical staff also recognised the need to share the clinical audits more widely to ensure shared learning. One of the GPs told us they had started doing this at a partners' meeting in January 2015.

The practice was applying the gold standards framework for end of life care, focusing on advanced care planning and holistic care, and reviewing the care provided for patients. Regular internal as well as multidisciplinary meetings were held, to discuss the care and support needs of patients and their families.

Effective staffing

Staff told us they worked well together as a team. Our findings supported this. The practice had a motivated and established team with appropriate knowledge, skills and experience to enable them to carry out their roles effectively. This ensured continuity of care and services.

The skill mix and numbers of staff had been strengthened by appointing a team leader for the three branch locations, a nurse manager to lead the nursing team, a second operations manager and a further health care assistant. These were new posts to help ensure the services were effective.

Staff told us they had received appropriate induction training to enable them to carry out their work, which they found helpful. We saw that an induction process and checklist was in place for staff but this was not role specific. The induction was supported by an up to date staff handbook, which contained various key policies along with essential information and guidance for staff.

Senior managers told us of plans to develop the induction programme, to ensure that all staff received appropriate training to carry out their work. This was set out in the provider's development plan.

Records showed that staff had attended various training relevant to their role. This included mandatory courses such as infection control , fire safety and basic life support. A monthly protected learning event was held, which staff were supported to attend.

Staff told us that they were supported to attend relevant training, to develop their skills and meet patients' needs. For example, a healthcare assistant (HCA) had received appropriate training to enable them to undertake blood tests, B12 injections and patients' blood pressure. They had also received training to use the electrocardiogram, to record the rhythm and electrical activity of a patient's heart.

The HCA told us they were observed undertaking the above procedures to ensure they were competent to carry out the tasks. We saw that records were completed to support this. The HCA was also being supported to attend an ear syringing course, and training on anticoagulant testing to develop their role and meet patients' needs.

The practice had recently appointed a nurse manager who was an advanced nurse practitioner. They had a clear vision for improving the quality of nursing care, and delivering a consistent approach across all three branches. The manager was assessing work practices, and ways of providing more efficient services for patients. This included developing clinical audit tools and supervision for nursing staff, to ensure there was a robust assessment of their performance.

Several staff told us they had not had an appraisal in the last year. The senior managers had identified that their appraisal system was not sufficiently robust, and did not fully support the personal development of staff. They told us that the annual appraisal plan had been put back, to enable them to develop a new performance review form linked to the practice's business plan. This had recently been completed and approved for use.

We were assured that a revised appraisal plan was in place for all staff to be appraised in 2015. The nurse manager would carry out the nurses' appraisal. All staff would have a personal development plan, which outlined their training and learning needs.

The GPs demonstrated that they were up to date with their yearly professional development requirements, and 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).

Good

Are services effective?

(for example, treatment is effective)

The practice was not a training practice but offered second and fifth year placements to medical students. There were no students placed at the practice when we did our inspection.

Working with colleagues and other services

Our findings showed that the practice worked closely with other service providers and professionals to meet patients' needs. The practice held separate monthly primary care meetings, to discuss the needs of vulnerable children and adults. The adult meetings included patients with complex needs or at risk of unplanned admissions to hospital. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

The adult primary care meetings were attended by district nurses, social workers, physiotherapist, community matron, and other professionals involved in patients care. The children's meetings were attended by health visitors, midwives and school nurses.

Patients receiving end of life care were supported by the district nurses and specialist Macmillan nurses. The practice kept a register of patients receiving end of life care. Patients' needs were discussed and reviewed at the monthly primary care meetings. All relevant staff involved in their care including GPs, district nurses and Macmillan nurses were invited and expected to attend.

Decisions about patients' needs were documented in a shared care record. Staff felt the systems worked well and provided a means of sharing important information.

Information sharing

A system was in place to coordinate records and manage patients' care, and enable essential information to be shared in a secure and timely manner. The system enabled scanned paper communications, such as those from hospital, to be saved for future reference.

Staff used Emis electronic system to coordinate, document and manage patients' care. The practice received test results, letters and discharge summaries from the local hospitals and the out-of-hours services both electronically and by post.

A policy was in place outlining the responsibilities of relevant staff in passing on, reading and acting on any issues arising from communications with other providers. .

The practice planned to move over to SystmOne in 2015, which is a centralised clinical system, which was used by most providers and practices in the area. This will further enable the practice to share information with other providers.

We saw that test results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly seen, coded and followed up by the GPs, where required.

Electronic systems were in place to enable referrals to other providers be made promptly. The practice was signed up to the electronic Summary Care Record, which provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. For example, the notes for patients receiving end of life care included essential information about their needs, medicines and wishes.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment.

Clinical staff told us that they obtained patients' informal consent before they provided care or treatment. There was a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment. We saw evidence that formal consent had been obtained for patients who received minor surgery.

Clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004, and understood their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice. Records showed that most staff had received relevant training to ensure they understood the key parts of the legislation, and how they applied this in their practice.

Staff told us that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or

Good

Are services effective?

(for example, treatment is effective)

more frequently if changes in circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

We saw that a wide range of health promotion information was available to patients and carers

on the practice's website, and the noticeboards in the waiting area.

Patients we spoke with told us GPs would give them advice and guidance about maintaining a healthy lifestyle.

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.

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 had also identified the smoking status of 97.4% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. GPs took the opportunity to follow up any screening or monitoring needed to ensure patient's health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 346 patients in this age group took up the offer of the health check in the past 12 months.

Records showed that 82.2% of patients aged 65 years and over, had received an influenza immunisation in the 2014/ 2015 period to reduce the risk of them developing flu.

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 patients with a learning disability, experiencing poor mental health, those in vulnerable circumstances, with long term conditions and older people. They were offered an annual health check, including a review of their medicines.

The practice was involved in a wide range of screening programmes including bowel, breast and cervical screening. Data showed that 83% of women aged 25 to 65 years had received a cervical screening test in the last 5 years, which was above the national average (83%).There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited those who do not attend. A named nurse was responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 to 2014 data for childhood immunisations showed that the percentage of children receiving vaccinations was above the CCG average rates.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients expressed high levels of satisfaction with the care and the approach of staff. They described the staff as friendly, helpful and caring, and felt that they were treated with dignity and respect. They also said that they felt listened to and that their views and wishes were respected.

Staff and patients told us that consultations and treatments were carried out in the privacy of a suitable room. We noted that conversations could not be overheard. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. 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.

We reviewed the most recent data available for the practice on patient satisfaction. This included the 2015 national patient survey, which 121 patients completed, and the practice's 2014 survey**.** The data showed patients were treated with care, dignity and respect. Patients' levels of satisfaction when they last saw or spoke to a GP, was higher compared to when they saw or spoke to a nurse. For example, the national survey data showed that 97% of people said the last GP they saw or spoke to was good at treating them with care and concern, compared to 87% when they last saw or spoke to a nurse. The team were aware of this issue and had taken active steps to address this.

A nurse manager had recently been appointed. They were establishing systems and protocols to govern the work of the nurses, and provide a consistent approach to the care patients received.

We also reviewed the patient reviews of the practice on NHS Choices completed in the last 12 months. All three comments were very positive about the care and treatment patients received.

Care planning and involvement in decisions about care and treatment

Patients said that they felt listened to, and were involved in making decisions about their care and treatment. They were given sufficient time and information during consultations to enable them to make informed choices. However, two patients said they sometimes felt rushed when the appointment times ran late. Feedback on the comment cards we received were also positive in this area.

The 2015 national patient survey showed that patients responded very positively about GPs involving them in decisions and explaining tests and treatment (92% and 96% of patients respectively) However, their satisfaction in these areas when they saw a nurse was less positive (82% and 89% of patients respectively) and was lower than the Clinical Commission Group average.

Clinical staff told us that patients at high risk of unplanned admissions to hospital, including elderly patients and those with complex needs, or in vulnerable circumstances, had a care plan in place to help avoid this. The care plans included patient's wishes, including decisions about resuscitation and end of life care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed that patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with during the inspection and comment cards we received were also consistent with the survey information.

Patients told us that were supported to manage their own care and health needs, and to maintain their independence, where able.

A carer's notice board was displayed in the patient waiting room, and an information pack was also available. The practice's website also told patients how to access a number of support groups and organisations. Carers' details were included on the practice's computer system, to alert staff if a patient was also a carer to enable them to offer support.

Data we reviewed indicated that a higher percentage of patients with caring responsibilities were registered with the practice than the England average.

Staff we spoke with demonstrated that importance was given to supporting carers to care for their relatives,

Good

Are services caring?

including those receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from their usual GP, to determine whether they needed any practical or emotional support.

One patient we spoke to who had had a bereavement confirmed they had received this type of support, which they had found helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice was responsive to their needs. The main practice we inspected at the Cropwell Bishop did not have any patients registered in local care homes.

There was a holistic and pro-active approach to meeting patients' needs. The practice knew the needs of their patient population well. The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other services. For example, the clinical staff held monthly clinics with the diabetes specialist nurse to review patients whose diabetes was not well controlled. This enabled patients to be treated locally.

The practice engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had signed up (along with all other practices in the CCG) to provide urgent weekend appointments with a GP from a local location. This was part of the Prime Minister's Challenge Fund to improve patient access to primary care.

The practice was signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. Staff told us they operated a patient list culture, accepting patients who lived within their practice boundary.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

The services for patients were located on one level. The premises were accessible and had been adapted to meet the needs of people with disabilities, including patients in a wheelchair.

The practice had a 99% white British population. We saw that a translation service and information was available in various languages, for patients whose first language was not English.

Staff we spoke with said that they had attended equality and diversity training. They also said that equality and diversity issues were discussed at team meetings. Records we looked at did not show that all staff had attended the above training. The practice manager agreed to update the records and ensure that all staff attended the training.

Access to the service

Patients told us they were able to access the service when they needed to. They described their experience of accessing appointments as good, with urgent appointments usually available the same day or were offered a telephone consultation, where needed. They said they usually did not have to wait long to get an appointment with their preferred doctor. They also told us that although there were sometimes delays in their appointment time, they did not consider these excessive.

The latest national GP survey showed that 76% of people who completed this found it easy to get through to this surgery by phone. Also, 88 % were able to get an appointment to see or speak to a clinician the last time they tried.

There is a single patient list across the three branches. This meant that patients could ask for an appointment at any of the three branches as there is a shared clinical system. This offered patients a high degree of flexibility. Patients were able to book an appointment in person, by telephone or on line. Non-urgent appointments could be pre-booked in advance.

We found that the appointment system was flexible to meet the needs of patients. Staff offered patients a choice of appointments to meet their needs, where possible.

We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who were not well enough to attend the practice. Staff added patients who needed to be reviewed urgently to the appointments to be seen that day, or arranged for a call back from a GP, where appropriate. Where possible, telephone consultations and home visits were undertaken by a GP who knew the patient best.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for people who needed them, including those with long-term conditions, a learning disability or experiencing poor mental health. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. When closed, an answerphone message gave patients the telephone number they should ring depending on their circumstances.

The practice was open from 8.30 am to 6.30pm Monday to Friday with the exception of Tuesday when the practice closed at 12 midday.

The practice had opted out of providing out-of-hours services to their own patients, although they were signed up (along with all other practices in the CCG) to provide urgent weekend appointments with a GP from a local location. This is part of the Prime Minister's Challenge Fund to improve patient access to primary care. This enabled children and young people to attend appointments outside of school hours. It also enabled patients who worked and those unable to attend in the day to attend at weekends.

At all other times patients could contact the out of hours service outside of practice opening hours, which is provided by NEMS Community Benefit Services. We saw that the information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website.

The business manager told us that they regularly reviewed the appointment system and telephone response times, to ensure it met the demands on the service. We saw evidence of this.

Listening and learning from concerns and complaints

Patients said they felt listened to and were able to raise concerns about the practice. Not all patients were aware of the process to follow should they wish to make a complaint, but they said that they had not had cause to do so. We noted that limited information was available to patients to help them to understand the complaints procedure on the practice's website.

The complaints procedure was generally in line with current guidance and the NHS procedure for GPs in England. Although the complaints leaflet available to patients at the practice did not state that they could direct their complaint to NHS England rather than the practice, in addition to contacting the Parliamentary Health Service Ombudsman to investigate second stage complaints. The business manager agreed to update the information available to patients.

A system was in place for managing complaints and concerns. The practice team leader and the operations manager were responsible for handling complaints. They told us that most concerns were dealt with informally and were promptly resolved. Staff recorded informal concerns in the patients' notes rather than a separate record. This did not enable the practice to easily oversee and analyse informal concerns received.

Records showed that the practice had received four formal complaints in the last 12 months. These were acknowledged, investigated and responded to in line with the practice's policy, except for one complaint that was ongoing. Senior staff told us that all formal complaints were included as significant events, to ensure that appropriate learning and improvements had taken place.

The 2014 complaints log included complaints received across all three branches. Senior staff told us that they considered any trends and patterns, although the records did not clearly show this. Limited information was recorded under the 'any actions or learning outcomes' section to demonstrate lessons learnt and improvements made.

Staff told us that the practice was open and transparent when things went wrong, and that patients received an apology when mistakes occurred. Complaint responses we reviewed indicated that patients had received an apology, where appropriate.

Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that any concerns were shared with staff at team meetings, and were acted on to improve the service for patients. Records we looked at supported this.

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 purpose to provide patient centred, safe, effective and high quality care and services to patients. They also worked with colleagues to improve services and outcomes for other patients in the area. Staff we spoke with knew and understood the purpose and values of the service, and what their responsibilities were in relation to these.

Records showed that regular business meetings were held, where future plans were discussed.

The senior managers had set out a clear development plan for 2014 to 2017. This included developing; the IT systems to improve efficiency and access to information, the induction process and a robust appraisal system to support personal development, and a more efficient system for managing long-term conditions and acute services. Staff we spoke with were aware of the future plans, and were committed to new ways of working to ensure the service was well-led.

Governance arrangements

We found that effective systems were in place for gathering and reviewing information about the quality and safety of services that people received. Systems were also in place for identifying, recording and managing risks.

Records showed that regular business meetings were held to discuss the practice's finances, performance and future plans. Senior managers demonstrated a commitment to continuous improvements to the services.

In the last 12 months the skill mix and leadership of Belvoir Health Group had been strengthened by appointing a team leader for the three branch locations, a nurse manager to lead the nursing team and a second operations manager. These new posts had helped to drive improvements and ensure the services were well-led.

Records showed that various meetings took place to aid communication and the sharing of important information. The provider had a range of policies and procedures in place to govern the practice. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and that these were shared with staff. Twelve key policies we looked at had been reviewed recently and were up to date. We found that the policies were followed in practice.

Three monthly clinical governance meetings had recently been introduced out of the need to improve the sharing of clinical knowledge and learning. They involved all partner and salaried GPs and the nurse manager.

We saw that the practice had completed various audits to monitor and improve the quality of care and services for patients. However, these included limited clinical audits. The GP partners acknowledged the need to develop the clinical audit programme across the three branches, linked to medicines management information, safety alerts and significant events to improve outcomes for patients.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The 2013 to 2014 data for this practice showed that the practice achieved a total of 99.9%, scoring above the national and local average in all clinical areas assessed. Records showed that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a clear leadership structure. The GP partner's had lead roles including finance, medicines management and health and safety. All staff we spoke with were clear about their own roles and responsibilities. They told us that the practice had undergone various changes in the last 12 months. They felt that the changes were well managed and had strengthened the leadership at the practice.

Staff also said that they enjoyed their work and felt valued and well supported. They were usually involved in decisions about the practice. They described the culture of the organisation as open, and felt able to raise any issues with senior staff as they were approachable. The team leader and business manager had an 'open door' policy to discuss any concerns or suggestions.

Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

Are services well-led?

Good

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

A whistleblowing policy was available and staff were aware of this, but they had not had cause to use it. We were shown the electronic staff handbook, which included sections on equality, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The nurses we spoke felt that the nursing team was distanced from the GPs in regards to support and working well together as a team. The nurses and other staff were not involved in any meetings with the GPs, to enable them to share learning and improve communication.

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

The practice obtained feedback from patients through surveys, comments and complaints.

The practice had an active Patient Participation Group (PPG), which is group of patients who work with the practice to represent the interests and views of patients, to improve the service provided to them. We spoke with the chair of the PPG. They told us that the group included patients from all three surgeries within the practice.

The PPG had tried to recruit further members with limited success. They were looking to set up a virtual PPG group by use of emails and by setting up a facebook page for patients to sign up to represent further patient groups. They were also looking to meet with other local PPGs to share ideas and ways of improving the services.

The chair of the PPG also met regularly with the local Clinical Commissioning Group, along with other PPGs to discuss issues affecting patient care. For example, looking at the care of patients diagnosed with diabetes to ensure they received the appropriate care.

The Patient Participation Group (PPG) worked in partnership with the practice to improve the services. The PPG chair told us that the practice was reasonably good at responding to feedback from patients. For example, the patient telephone number had been changed from a premium to a local number in response to patient feedback.

The business manager showed us the findings of the latest patient survey, which was considered with the PPG. The results of the March 2014 survey generally showed that patients were satisfied with the care and services. The PPG had agreed the action points from the last survey.

Discussions with staff and records we looked at showed that the practice obtained feedback from staff through team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the quality of the services provided.

Management lead through learning and improvement

Records showed that staff received on-going training and development to enable them to provide high standards of care. Staff told us that they were supported to acquire new skills and develop their knowledge to improve the services. For example, one of the practice nurses had received training to enable them to initiate insulin treatment at the practice for appropriate patients with diabetes.

The practice had arrangements for identifying, recording and managing risks. Records showed that incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions, learning and improvements had taken place to minimise further occurrences.