East Leake Medical 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 East Leake Health Centre on 4 February 2015. Overall the practice is rated as Outstanding.

We found the practice to be outstanding for providing, responsive services and for being well led and good for providing safe, effective and caring services. It was also outstanding for providing services for the population groups, of people experiencing poor mental health (including people with dementia) and families, children and young people.

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

- The practice worked with other local providers to share best practice to improve patient outcomes.
- Patients told us they very happy and satisfied with the care and treatment they received. They said they were treated with compassion, dignity and respect by all staff.
- Patients felt involved in their care and able to make informed decisions about their treatment.
- The practice actively sought feedback from patients using a variety of methods and acted on suggestions for improvements and made changes to the way it delivered services based on this feedback. The practice had an active Patient Participation Group (PPG), who worked in partnership with the practice to further improve services for patients.
- The practice was accessible to all patients and was well equipped to treat patients and meet their 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.
- The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet needs, and drive continuous improvements.
- The practice had a clear vision which had quality and safety as its top priority. Systems were in place to keep patients safe and minimise risk of harm. When things went wrong the practice had an open culture which ensured lessons were learnt and improvements made.

Summary of findings

- The management and governance of the practice assured the delivery of high-quality person-centred care.
- Staff were actively supported to continually develop their knowledge and skills to ensure the delivery of high quality care. The practice had a highly motivated and committed staff team with extensive experience and skills, to enable them to deliver well-led services.
- The practice had a very good skill mix which included advanced nurse practitioners (ANPs) who were able to see a broader range of patients than the practice nurses. This had enabled greater access to appointments for patients and freed up time for training and development for all staff. There was a preceptorship, mentoring and support programme in place to support new ANPs to the practice.
- GP's gave their personal phone numbers to families and carers of patients receiving end of life care to ensure they could be contacted if needed. Following bereavement a personal letter of condolence was sent by the GP who knew the patient best. This was followed up with welfare calls.
- The practice had instigated a 'Red Dot' system to identify patients with multiple long term conditions and ensure they were allocated longer single appointments to have health checks for each of their conditions, This had reduced the number of appointments required for these patients, ensured greater continuity of care and increased access to appointments for other patients .
- The practice provided a dispensary service for patients at a branch surgery to ensure they had ease of access to medicines.

We saw several areas of outstanding practice including:

- The practice worked with a voluntary partner to develop a strategy to support young people in crisis and at risk of suicide. The programme had been adopted across the county.
- Staff were supported to a very high standard and had access to training funded by the practice to help develop their skills. For example a nurse was supported to undertake a diabetes merit course which enabled them to run joint diabetes clinics which increased access to and effectiveness of care. The practice had been recognised by the CCG and Nottingham University as a particularly supportive placement for students and GP registrars.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Systems were in place to keep patients safe and minimise risk of harm. When things went wrong the practice had an open culture which ensured lessons were learnt and improvements made.

The practice used every opportunity to learn from internal and external incidents to support improvement. Information about safety was highly valued by the whole practice team and was used to promote learning and improvement. Risk management was comprehensive, well embedded and was recognised as the responsibility of all staff. There were enough staff on duty to keep patients safe.

The practice had a lead GP for safeguarding children, and this GP was involved in multi-disciplinary meetings, including attending child protection case conferences and reviews.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines.

QOF (Quality and Outcomes Framework) data showed that the practice was performing better than most when compared to neighbouring practices in the CCG, for example treatment of asthma, cancer and heart failure.. Practice staff were supported to gain additional skills and qualifications, which helped promote good practice and improve outcomes for patients.

The practice was committed to collaborative working with other providers to ensure patients received coordinated care, for example working with local care homes, community nursing staff and mental health support staff.

The practice used regular clinical audit cycles to monitor the effectiveness of the service and further improve outcomes for patients.

Staff used targeted health promotion to support patients to live healthier lives and reduce ill health. For example, combined health checks for patients with multiple long term conditions and opportunistic health checks for patients who expressed concerns

Summary of findings

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture, for example listening to and acting on patent feedback around appointments and access to services and support for families and carers following bereavement. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

GP's gave their personal phone numbers to families and carers of patients receiving end of life care to ensure they could be contacted if needed. Following bereavement a personal letter of condolence was sent by the GP who knew the patient best. This was followed up with welfare calls. Informal feedback to the practice indicated that patients valued this support and sympathy.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

The practice had led and initiated positive service improvements for its patients that were over and above its contractual obligations. For example, the Tomorrow Project (a project aimed at promoting positive mental health and reducing suicide amongst young people) and leading on the Saturday GP appointment service across the CCG which was a Prime Minister's Challenge Fund initiative to enable better access to patients across the CCG out of normal surgery hours.

It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). For example changes to the appointment and telephone systems. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

The practice worked with a voluntary partner to develop a strategy to support young people in crisis and at risk of suicide. The project included talking therapies, counselling and referral to additional support. The programme had proved successful and had been adopted across the CCG area. Data showed that 84 patients across the CCG area had accessed this service and over 1000 young people had received training, talks and informal support from staff of the project.

Summary of findings

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments 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 and other stakeholders.

The practice provided a non-profit making dispensing service at a branch surgery to provide a service to the community and its own patients, avoiding the need to travel. Patients at the dispensary told us they valued the service as they could collect prescriptions easily without having to use public transport. A survey carried out by the practice identified that all patients who used the dispensary were happy with the service and found it beneficial.

Are services well-led?

Outstanding 

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

The practice had a clear vision which was embedded in every aspect of the service and its delivery to patients. Quality, improvement and safety were the practice's top priority.

The strategy to deliver this vision had been produced with stakeholders such as the patient participation group and was regularly reviewed and discussed with staff at East Leake Medical Centre. High standards were promoted and owned by all practice staff and teams worked together across all roles to secure the best possible outcomes for patients. The practice was also outward looking and considered the needs of the wider local community and designed and delivered services to enable the wider locality to receive improved access and services. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The governance and quality systems were constantly evolving in response to feedback.

The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and high levels of staff satisfaction were evident and reported. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG). The practice had conducted a patient survey during February 2014 and 424 patients responded.

A business plan was in place, was monitored and regularly reviewed and discussed with all staff.

Summary of findings

Staff were supported to a very high standard and had access to training funded by the practice to help develop their knowledge, skills and competence to undertake their roles and develop them as professionals.	

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, for example rheumatoid arthritis and heart failure.

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 support of care homes and monitoring patients with long term conditions. It was responsive to the needs of older people and those in care homes by offering joint visits by the GP and community nurse which had resulted in fewer emergency calls and improved patient outcomes. Longer appointments were available for those who required them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. A comprehensive annual review was offered to patients with long term conditions such as, diabetes, asthma, chronic heart disease (CHD) and hypertension (high blood pressure). The practice had instigated a 'Red Dot' system to identify patients with multiple long term conditions and ensure they were allocated longer appointments to have annual reviews for all their conditions at one appointment. The practice had recorded that 50% of patients identified as requiring the longer appointments had accessed one this year.

Where possible, reviews were carried out by the same nurse or other clinician to ensure continuity of care for patients. Additional training had been provided to the healthcare assistant to enable them to carry out annual health checks.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments of up to one hour and home visits were available where required. All these patients had a named GP. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had designed and implemented its own templates to monitor and risk assess patients with long term conditions which improved outcomes. The lead partner at the practice was also the lead GP for long term conditions with the CCG which helped ensure best practice was in place.

Summary of findings

Families, children and young people

Outstanding ☆

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

The practice had signed up to the Family Nurse Partnership. This is a national programme which provides staff with resources and training to support young mothers and fathers. The programme aims to improve the parenting skills of vulnerable young people.

The practice had innovative ways of working with this patient group. For example, following a cluster of suicides of young people in the local area, the practice had worked with a voluntary partner to develop a strategy to support young people in crisis and at risk of suicide. The project included talking therapies, counselling and referral to additional support. The programme was adopted across the county. Data showed that 84 patients across the CCG area had accessed this service and over 1000 young people had received training, talks and informal support from staff of the project.

All day access to health visitors, community midwives and a counselling service was offered at the practice, which significantly improved access for young patients and families.

Patients and staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Childhood immunisations were similar to or above CCG average at all age groups and above CCG and National averages from age five upwards. For example practice figures for Hib/Meningitis C Booster at age five was 95.2% compared to a CCG figure of 92.2%.

Working age people (including those recently retired and students)

Good ●

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered appointments from 7am on Tuesday and Thursday. Additionally patients were actively encouraged to say if they felt they would need a longer appointment via the practice website. The practice was proactive in offering online services as well as a full range of health promotion and

Summary of findings

screening that reflects the needs for this age group. For example 86.5% of eligible patients had attended for cervical screening. This was above the CCG and National figures of 83.4% and 74.3% respectively.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had attended for a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. For example Citizens Advice Bureau and carers support groups. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Specific training for GP registrars was given on how consultation skills and shared decision making for vulnerable patients. We saw that this was followed by reflection on these skills with the registrar's mentor. This led to safer, more consistent care and improved clinical outcomes for patients

Appointments of up to one hour were available to people in vulnerable circumstances and those with long term conditions

Patients who were unable to access the service could nominate a named person to discuss pathology results and collect repeat prescriptions.

People experiencing poor mental health (including people with dementia)

Outstanding

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

Eighty-six percent of people experiencing poor mental health had received an annual physical health check. This was better than both the local CCG and National averages of 81% and 78% respectively. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice had proactively identified a need to develop strategies and support for young people in the area following a cluster of suicides. They had worked with a voluntary partner to develop a strategy to support young people in crisis and at risk of suicide. The project included talking therapies, counselling and referral to additional support. The programme was adopted across the county. Evidence showed that 84 patients across the CCG area had accessed this service and over 1000 had received training, talks and informal support from the project.

An IAPT (Improving Access to Psychological Therapies) team was based at the practice with clinics offered three times per week and throughout the day to enable young people to access these services at convenient times for them.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 30 completed comment cards. All were positive and expressed views that the practice offered an excellent service with understating, caring and compassionate staff, and committed, caring GPs. Two comments were from NHS professionals attached to the practice, both making positive comments.

The practice had conducted a patient survey during February 2014 and 424 patients responded. Responses were overwhelmingly positive, with the majority of patients rating the practice as very good. In addition the 2014 GP Patient Survey of 108 patients' demonstrated patients rated the practice highly in a number of areas. 91% of patients who responded said the reception staff were friendly, 81% said it was easy to get through on the phone and 96% said the nurse was good at listening to them. These compared favourably with CCG figures of 91%, 78% and 92% respectively.

We spoke with six patients during our inspection. All six patients said they were happy with the care they received, and thought the staff were all professional, approachable, and caring.

Outstanding practice

- The practice worked with a voluntary partner to develop a strategy to support young people in crisis and at risk of suicide. The programme had been adopted across the county.
- Staff were supported to a very high standard and had access to training funded by the practice to help develop their skills. For example a nurse was supported to undertake a diabetes merit course which enabled them to run joint diabetes clinics which increased access to and effectiveness of care. The practice had been recognised by the CCG and Nottingham University as a particularly supportive placement for students and GP registrars.

East Leake Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) inspector. The lead inspector was accompanied by a second inspector, a GP specialist advisor, plus a practice manager specialist advisor.

Background to East Leake Medical Group

East Leake Health Centre provides primary medical care services to approximately 9,200 patients. The practice is based in the centre of the village of East Leake in South Nottinghamshire. There are two branch surgeries located at Ruddington and Sutton Bonington, which makes a total patient population of approximately 12,800. Patients can be seen at any of the three locations

The practice offers a dispensary service at the Sutton Bonington branch which we visited. At both other surgeries an independent pharmacy is located close to the GP premises. We did not inspect the two branch surgeries.

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

There are seven GPs at the practice, six are partners, and one is a salaried GP. There are five male and two female GPs. In addition the nursing team comprises three advanced nurse practitioners and two practice nurses. The clinical team are supported by the practice manager and an administrative team. There are 5.7 whole time equivalent GPs working at the practice. In addition, there are just under three whole time equivalent nurses.

East Leake Health Centre has opted to host and take part in the Prime Minister's challenge fund weekend pilot. This has seen the practice working co-operatively with other GPs in the local area to provide a GP service on both Saturday and Sunday mornings and on Bank holidays.

During the evenings and after 1:00 pm at weekends, an out-of-hours service is provided by Nottingham Emergency Medical Services (NEMS) through the 111 telephone number.

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

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?

Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 February 2015. During our visit we spoke with a 12 members of staff (GPs, nursing staff and administration and reception staff) and spoke with five patients who used the service. We observed how people were being cared for and talked with patients We reviewed comment cards where patients shared their views and experiences of the service.

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. These were discussed at monthly practice meetings and learning points were identified and shared with staff. For example, we saw a record of an incident where a medicine was almost dispensed twice. Additional training and extra staff vigilance were put in place as a response. Records showed there had been no further incidents of this nature.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 11 years. This showed that thorough analysis of each incident and event had been carried out by the practice and any learning was disseminated to all staff. Evidence was available to show practice had managed incidents consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 10 years and we were able to review these.

Over the previous 12 months 11 significant events had been recorded. The records showed that for each significant event there was an outcome and learning points and actions recorded. Significant events were discussed at fortnightly GP partner meetings to ensure any actions had been followed up and at all monthly practice meetings to ensure all staff were aware of any learning. All staff we spoke with knew how to raise an issue and felt comfortable to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked 11 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example a request for onward referral was missed in a patient's hospital discharge letter which resulted in a delay in formal diagnosis for the patient. The practice had reviewed its processes for scanning letters and ensuring action was taken. This was reviewed at a clinical and scanners meeting and an audit of the process was undertaken. 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.

National patient safety alerts were disseminated by the managers of the three practice sites and the reception manager. They were then filed in a folder on the shared drive of the practice's computer records. Information was shared with appropriate practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example a recent alert sent to GPs warned of a potential link between a medicine for asthma and abnormalities in pregnancy. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately. For example a patient experienced delay in referral due to an error with a referral letter. The practice switched to a wholly electronic system which enabled all staff involved in the referral process to monitor its progression.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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.

Good

Are services safe?

We saw evidence of a multi-disciplinary meeting where safeguarding information relating to a child in vulnerable circumstances had been discussed.

The practice had appointed dedicated GPs as leads 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 staff we spoke with were aware who these leads were and who to speak with 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. Staff showed us how the computerised records identified patients who were identified as being vulnerable or 'at risk.' This included frail, elderly patients, patients with dementia, patients with learning disabilities and 'at risk' children and families.

We spoke with a Health Visitor who outlined how information related to child protection was discussed at regular multi-disciplinary meetings with the lead GP to ensure a co-ordinated approach. The health visitor confirmed staff from the practice attended child protection case conferences and reviews or sent reports if they were not able to attend.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff acted as a chaperone if nursing staff were not available. In 2012 all staff attended a workshop relating to chaperones and their role. More recently staff undertaken on-line chaperone training records confirmed all staff had either received this training or had this booked. . All of the staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to 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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, one of the GPs was also a qualified pharmacist. This enabled the practice to have robust and safe dispensing and medicines management procedures and policies. Regular, in depth audits of medicine and prescribing procedures were carried out by the practice which improved outcomes for patients and ensured best practice was observed. Patterns of antibiotic, and sedatives and anti-psychotic prescribing within the practice were being reviewed regularly and compared favourably to other local practices.

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. Three members of the nursing staff were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

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.

All prescriptions were reviewed and signed by a GP or ANP where appropriate, before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely 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 operating procedures that set out how they were managed. These were being followed by the practice staff.

Good

Are services safe?

For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. The CCG lead pharmacist was also invited in to carry out an independent audit. This helped identify any areas for improvement, ensure the practice was working to current best practice standards and offer reassurance that systems were safe and robust.

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. Dispensary meetings were held quarterly to review progress. These were attended by dispensing staff and GP's. The practice had funded staff working in the dispensary to achieve a NVQ Level 2 qualification

We saw that patient group directions (PGD) were in place. PGD are a legal framework that allows some patients to receive medicines or treatment from staff who are not doctors. We saw that PGD were in place to allow nursing staff to administer flu vaccines and some childhood immunisations.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit during March 2014. Records showed that learning points had been identified and improvements were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Regular audits had been completed and copies of audits were available for review. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of 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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

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

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

place for all the different staffing groups to ensure that enough staff were on duty. Arrangements were in place to ensure adequate staffing cover during periods of staff leave.

Staff told us there were always enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses. There was a preceptorship programme which offered guidance, training and clinical mentoring in place to support new ANPs to the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were identified and each risk was assessed with actions identified to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. We saw that risk assessments were in place for each individual treatment room and each area of the practice buildings. Steps had been taken to try and reduce identified risks. For example liquid nitrogen was stored in the nurse's room. A risk assessment had been carried out with the liquid nitrogen supplier and covered the risk of burns or asphyxiation. Protective equipment was provided and the room was adequately ventilated to ensure staff and patient safety.

Vulnerable patients and those with complex needs were discussed at monthly Multi-Disciplinary Team (MDT) meetings attended by Health Visitors, District Nurses, Community Matron and Midwife. Notes of these meetings showed that patients, carers and children at risk were identified and their situations discussed. There was recorded evidence to show that additional support was provided where necessary.

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 evidence we saw assured us that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: There were emergency processes in place for patients with long-term conditions. Staff gave us examples of acutely ill patients whose health deteriorated suddenly and the steps they had taken to ensure their safety. Emergency processes were in place for acute pregnancy complications. Staff were also able to provide us with examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

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 (heart attack), anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). 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. Each risk was rated and identified actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us they felt they received effective care from the practice. National and local performance data along with comment cards we received confirmed this.

The practice provided a wide range of services to meet patients' needs and had worked proactively to identify ways to provide effective patient care, for example offering longer, single appointments to enable patients with multiple long term conditions to have their health checks.

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. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs had lead roles 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. This enabled them to provide best practice support to their patients for those conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

A GP partner showed us data from the local Clinical Commissioning Group (CCG) and the practices own analysis of their practice's performance for antibiotic prescribing, which was below average compared to similar practices.. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within three days by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of cancer under the two week target. Results of an audit undertaken by the practice showed that of 82 patients with a new diagnosis of cancer, 93% were seen within the two week target. This exceeded both CCG and National figures. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Management, monitoring and improving outcomes for people

The practice showed us 10 clinical audits that had been undertaken in the last year. Six of these were completed audits where the practice was able to demonstrate the resulting changes since the initial audit. An audit of the use of antipsychotic medicines in a nursing home showed low prescribing numbers compared to figures gathered in the same audit completed during 2012. Other examples included; an audit of patients with a history of asthma who had been prescribed beta-blockers, a review of minor surgery and an audit of new cancer diagnoses for practice patients

Following each clinical audit, changes to treatment or care were made where needed and the audit was repeated to ensure outcomes for patients had improved. For example, we saw an audit in respect of the prescribing of a specific medicine for patients diagnosed with rheumatoid arthritis. The initial audit identified that 19% of these patients would benefit from adding the medicine to their repeat prescription. Changes were made to recording systems and a follow up audit identified that, although the number of patents on the study had increased; the number requiring an update to their prescription had fallen to 11% indicating patients were receiving the medicines they needed to manage the symptoms of their condition.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for

Good

Are services effective?

(for example, treatment is effective)

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). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with COPD chronic obstructive pulmonary disease (lung disease) had received an annual assessment of breathlessness. This was better than the CCG and National figures of 90% and 89% respectively. Eighty-seven percent of diabetic patients had received a dietary review in the last year. This was better than the CCG and National figures of 80% and 82% respectively. The practice met all the minimum standards for QOF. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

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 important courses such as annual basic life support. We noted a good skill mix among the doctors with five number having additional diplomas in sexual and reproductive medicine, and obstetrics and gynaecology, two with diplomas in children's health and five with qualifications in minor surgery. 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had received annual appraisals and any learning needs had been identified and recorded. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example dispensing staff at the practice had been funded to attend National Vocational Qualifications (NVQ) level 2 in dispensing. One of the practice nurses had been funded to receive training in chronic obstructive pulmonary disease (COPD) and spirometry (this is a test that can help diagnose various lung conditions, most commonly COPD).

As the practice was a training practice, doctors who were training to be qualified as GPs (Registrars) used extended appointments and had access to a senior GP throughout the day for support. There were robust systems in place to support doctors in training and to ensure that their treatment of patients was safe and appropriate. We saw that following each session carried out by a GP registrar they would discuss all consultations with their mentor to identify learning and offer support. Clinical support and confirmation for diagnosis and advice was available to all registrars and nurses from the GP's throughout the clinics.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, spirometry and asthma reviews. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate Diploma level training to fulfil these roles. The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses. We saw that in the preceding 12 months the ANPs had seen over 3400 patients which greatly improved access for patients to the practice. This additionally allowed other clinicians to undertake additional roles, see more complex cases and undertake training which improved outcomes for patients and staff.

There was a preceptorship programme in place which offered guidance, training and clinical mentoring to support new ANPs to the practice and continuous support and mentoring for the role. For example, ongoing mentoring is offered alongside GP Registrars (GPs in training) from a dedicated experienced supervising GP. This included advice and support during and after clinical consultations and the opportunity to discuss any cases and identify learning following clinics.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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. There were clear processes in place to make sure staff passed on, read and acted on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Other than one incident which was investigated fully, there were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate cases were documented and that none were missed.

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local 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 made 100% of patient referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice provided a summary care record for the patient to take to A and E in emergency situations to ensure continuity of care. The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by June 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system 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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice There was a policy in place in respect of consent and this included child consent. The policy gave clear guidelines with regard to different forms of consent. This policy highlighted how patients should be supported to make their own decisions about care and treatment and how these should be documented in the medical notes. There was a team approach to DNACPR's with District Nurses, GPs and relevant others involved in the assessment.

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 more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

All of the patients identified on the practice's learning disability register had been invited in to the practice for a review of their care plan in the last year. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a

decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Guidance regarding Gillick competencies was available in the practice's consent policy. The practice electronic recording system automatically created a 'pop up' on screen to record consent for patients aged 13-14.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, as a result of routine health checks, the practice had an increased rate of diagnosis for atrial fibrillation (a condition affecting the heart which was significantly higher than local and national averages.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 57% of patients in this age group took up the offer of the health check. The practice had a system in place to search the patient database monthly to identify patients who had not attended for this check and contact them via telephone or letter.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, there were 22 patients on the learning disability register. Records showed that all of these patients had been offered an annual physical health check. Practice records showed 100% (all 22 patients) had received a check up in the last 12 months.

The practice had also identified the smoking status of 80% of patients over the age of 16 and actively referred patients to New Leaf smoking cessation clinics run by the CCG. Figures from the New Leaf project showed 76% of all patients who attended had quit smoking. The practice had completed their own audit which showed broadly similar figures.

The practice's performance for cervical screening uptake was 91%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for screening with a named nurse responsible for following up patients.

Performance for national breast cancer (86%) and bowel cancer (69%) screening in the area were all above average for the CCG (81% and 67%, respectively), and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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

The practice had taken a lead within the CCG in the preparation of a funding bid to Sport England in February 2015. This was for funding for a three year pilot, to begin in June 2015, aimed at promoting exercise for patients with a number of long-term conditions including diabetes and respiratory disease across 60 practices within the CCG.

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 from January 2015 and a survey of 424 patients undertaken by the practice's patient participation group (PPG).The evidence from both 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 2015 national GP patient survey showed 76% of patients rated the practice as good or very good. The practice was also well above local and national average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 84% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and all contained positive comments. Patients used words such as brilliant, excellent and very good to describe the practice. Patients also said staff treated them with dignity and respect. Two patients commented that seeing a specific GP could be difficult. We spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private In addition music was played to mask patients' conversations.

Patients with learning disabilities, those who may feel vulnerable and people experiencing poor mental health were given longer appointments. Additionally they were able to wait in a quiet area and where possible were taken straight through to the GP.

GP registrars received specific training in respect of developing consultation skills and shared decision making with vulnerable patients. We saw that this was followed by reflection on these skills with the registrar's mentor.

The practice had a designated lead partner for mental health, depression and dementia. The practice ensured the needs of this group of patients were considered in all actions and developments. We saw evidence of this from clinical and practice meeting notes.

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 2015 national patient survey showed 71% of practice respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results. Both these results compared favourably to local CCG area and national results.

Patients we spoke with 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.

Staff told us that translation services were available for patients who did not have English as a first language. The electronic self-check in for patients was available in three languages.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients

Good

Are services caring?

we spoke to on the day of our inspection told us they had received help to access support services to help them manage their treatment and care when it had been needed. Comment cards we received confirmed this. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. For example along with leaflets and posters in the waiting areas, the practice website had a dedicated section for patient resources. This included links to local and national support agencies including, AGE UK, MIND (the mental health support charity), Citizens Advice Bureau, Alzheimer's Society, CCG, Relate and the British Heart Foundation.

The practice leaflet contained a comprehensive list of contact details and useful information. The final four pages of the leaflet offered first aid and self-treatment advice

Staff told us that if families had experienced bereavement, their usual GP contacted them with a personalised letter and telephone call. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. GP's we spoke with showed genuine compassion and understanding for patients and carers who had experienced bereavement. We saw that notes of welfare calls and conversations were recorded on patient notes, in one example this covered a period of almost two years. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

We saw that GP's gave their personal on call phone numbers to carers and families of patients who were nearing the end of their life to enable them to contact them at evenings and weekends.

The practice was working towards the gold standard framework for end of life care. We saw that the practice had competed an after death audit using the gold standards framework. This showed that 100% of patients on the palliative care register that expressed a preferred place of care received care in that location. The audit also showed that benefits advice was given, and that communication was maintained with other organisations involved in the care. We saw that further learning from the audit was shared with staff.

Outstanding ☆

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 highly responsive to patients' needs. The needs of the practice population were not only understood but there were robust systems in place to identify and improve the services for both the practice patients and the wider community. For example by hosting the Saturday and Sunday GP appointment service across the CCG which was a Prime Minister's Challenge Fund initiative to enable better access to patients across the CCG out of normal surgery hours.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged proactively with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice provided a non-profit making dispensing service at a branch surgery to provide a service to the community and its own patients, avoiding the need to travel. Patients valued the service as they could collect prescriptions easily without having to use public transport. A survey carried out by the practice identified that all patients who used the dispensary were happy with the service and found it beneficial.

The practice had signed up to the Family Nurse Partnership. This is a national programme which provides staff with resources and training to support young mothers and fathers. The programme has the aim to improve the parenting skills for vulnerable young people.

The practice had a dispensing service at a branch surgery. This branch was in a more rural location which was not well served by public transport. Staff we spoke with told us the service did not make a profit but the practice were committed to continuing to provide this as a service to their own patients and the wider community to avoid people having to travel to receive their medicines. Patients we spoke with told us they valued the service as it meant they could collect their prescriptions in a convenient location without having to undertake an extended journey on public transport. A survey carried out by the practice identified that all patients who used the dispensary were happy with the service and found it beneficial. Evidence showed that 82% of eligible patients used the service with over 24,000 items dispensed indicating it was valued and the services were used by the local community.

The practice had taken steps to ensure it was accessible and supportive for people in vulnerable circumstances and those experiencing poor mental health. For example patients in these groups were allocated a named and accountable GP to ensure continuity of care. The building was fully accessible to people with reduced mobility and complied with all disability discrimination act standards. The practice had a named lead for dementia, depression and mental health and personalised care plans were in place for patients with dementia.

Joint visits by the GP and district nurse were provided to care homes and for patients who experienced difficulty in accessing the service. This had led to a 43% decrease in the number of emergency services contacts compared to the previous year. Additionally the joint working had enhanced professional relationships and information sharing between GPs and community staff. Improved communication between the practice and care homes which has resulted in greater in depth knowledge of patients, more anticipatory care plans improvements to medicines management and prescribing and greater access for patients and their families to GP care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example appointments of up to one hour were available to people in vulnerable circumstances and those with long term conditions. The practice had recorded that 50% of patients identified as requiring the longer appointments had received one this year. A medicines home delivery service was provided for patients unable to attend the practice or travel to a pharmacy. Vulnerable patients could nominate a named person to receive their test results and order repeat prescriptions on their behalf. The practice had 268 patients identified as being vulnerable at the time of our inspection. We saw evidence which showed this service had been offered to all of them.

The practice had access to online and telephone translation services, although staff said they were rarely used as the majority of patients had English as their first language.

The practice provided equality and diversity training through an e-learning provider. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality

Are services responsive to people's needs?

(for example, to feedback?)

and diversity was regularly discussed at staff appraisals and team events. Staff training records identified 30 out of 45 staff had completed this training. This training was being rolled out on an annual basis, and all staff had been identified for refresher training.

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.

Access to the service

The practice had implemented a number of suggestions for improvements and had made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the 2009 patient survey identified access as an issue. This prompted the practice to trial a number of different systems including carrying out a mapping exercise of its own demand and availability, and working with the PPG to develop a bespoke system which included the recruitment of additional staff.

The practice had considered how to make the best use of its resources to improve access to the service and the data we reviewed indicated that in the preceding 12 months the Advanced Nurse Practitioners (ANPs) had seen over 3400 patients which greatly improved access for patients to the practice. This additionally allowed other clinicians to undertake additional roles, see more complex cases and undertake training which improved outcomes for patients and staff.

The patients we spoke with were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said 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 been able to make appointments on the same day of contacting the practice

Appointments were available from 08:30 am to 12:00 pm on weekday mornings, and 3:00 pm to 6:00 pm on weekday afternoons. In addition the practice opened early Tuesdays, Wednesdays and Thursdays at 7:00 am. Dedicated children's clinics were offered from 2:00pm to 3:30pm and the practice had a children's play are in the waiting room.

We saw that 293 planned and drop in appointments at these clinics were recorded. This was 68% of the registered children at the practice. At weekends the practice hosted and provided GPs to support the Prime Minister's challenge fund weekend pilot. This had seen the practice working co-operatively with other GPs in the local area to provide a GP service on both Saturday and Sunday mornings and on Bank holidays. During the evenings and after 1:00 pm at weekends an out-of-hours service was provided by Nottingham Emergency Medical Services (NEMS) through the 111 telephone number.

Comprehensive information was available to patients about appointments on the website and in the printed practice guide available in reception. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care homes on a specific day each week, by a named GP and to those patients who needed one. Patients with learning disabilities, those who may feel vulnerable and people experiencing poor mental health were given longer appointments. Additionally they were able to wait in a quite area and where possible were taken straight through to the GP.

We saw that records for patients with long term conditions or those who required additional support and may require longer appointments were identified with a 'red dot'. This ensured all staff were aware that additional support may be required.

Listening and learning from concerns and complaints

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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

We looked at 14 complaints received in the last 12 months and found they were handled in a timely way and in line with the practice complaints policy. Complaints showed evidence of thorough investigation involving several members of staff and appeared to have been resolved to the complainant's satisfaction.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the 2013/14 and 2102/13. No themes had been identified. However, lessons learned from individual complaints had been acted on.

Staff we spoke with told us that any learning from complaints was discussed at team meetings and were necessary, changes to practice were implemented.

Are services well-led?

Outstanding ☆

(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 strategy and objectives aimed at ensuring the continuous improvement of the service and achieving the best possible outcomes for patients. The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable and had been developed with other stakeholders including the Patient Participation Group.

The practice had a clear vision to improve the health of patients by serving and advocating for patients which was embedded in the approach of all practice staff and in the way the service was developed and delivered. There was a systematic approach to working with other organisations to improve care outcomes for the local population. For example leading on the Sport England 'Fit4Life' project a three year pilot, to begin in June 2015, aimed at promoting exercise for patients with a number of long-term conditions including diabetes and respiratory disease across 60 practices within the CCG. The practice had also worked with local voluntary and statutory groups to establish, promote and operate the 'Tomorrow Project' aimed at suicide prevention and promoting good mental health by using talking therapies, counselling and referral to additional support.

Staff informed us that their vision was to provide a vibrant service, chosen for clinical excellence, standing in partnership with patients, employees and clinicians, to improve the health of all communities served. We found details of the vision and practice values were part of the practice's strategy and long term business plan. These values were clearly embedded in everything the practice did. The practice vision and values included offering excellent access of service to the whole community and providing excellent care from friendly and well trained staff.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The practice had a strategic business plan which identified the practice's mission, values and vision.

Governance arrangements

The governance and oversight of the practice, systems, safety and effectiveness was robust and ensured positive outcomes were consistently delivered. There was a clear leadership structure with named members of staff in lead roles and this was supported by a consistent staff team. Each area of the practice had a GP or nurse lead and administrative support. For example, there was a lead nurse for infection control and two partners were leads for safeguarding. The practice also had clinical lead roles such as mental health, dementia and long term conditions. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns and they told us their opinions were valued.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All eight policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was consistently performing above national standards. For example performance for treatment of stroke was 2.3% higher than local CCG performance and 3.7% higher than national performance We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice were reflective and looked for opportunities to learn from others who were external to their own organisation as part of their commitment to continuous improvement. The practice staff were part of a local peer support system with 12 neighbouring GP practices. The peer support sessions included nurse specific training and development. Additionally all nurses attended a monthly in house practice nurse meeting and a separate monthly whole practice meeting. This enabled nurses to get support from their colleagues, share learning and best practice, enhance their skills and ensure they were informed about practice and CCG developments, leading to improved outcomes for patients within their own service.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Those we inspected assured us that this process was robust and that improvements

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could be made to patient outcomes which was shared with the whole practice team. . There was a systematic approach towards audits with actions in place to ensure that cycles were completed.

The practice had robust and effective arrangements for identifying, recording and managing risks which assured us that the practice took action to militate against these where possible and ensure the safety of patients, staff and others who may be at risk of harm.

The practice held monthly governance meetings. These related to clinical issues, business, reception and multi-disciplinary meetings. We looked at minutes from all four of the last monthly meetings and found that performance, quality and risks had been extensively discussed.

Leadership, openness and transparency

Leaders had an inspiring shared purpose, striving constantly to deliver outstanding service and motivate staff to succeed. The practice used feedback from staff appraisals to identify training needs for staff which would enhance the clinical aims of the practice and improve outcomes for patients. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Team meetings were held regularly, at least monthly. Staff told us that there was an open and transparent culture within the practice and they were happy to raise issues at team meetings or in between.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example recruitment procedures and the equal opportunities policy) which were in place to support staff. We were shown the electronic 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.

Staff had a thorough knowledge of the practice policies, procedures. We saw evidence that staff had ownership of these and had written protocols relevant to their role. For example the scanning protocol was written and reviewed by the scanning officer. This ensured the protocols were written from a perspective of first-hand knowledge and would be relevant to the staff using them and those that followed.

Seeking and acting on feedback from patients, public and staff

Rigorous and constructive challenge from people who use services, the public and stakeholders was encouraged and welcomed. Practice staff saw this as a vital way of reviewing and improving services, ensuring they met the needs of patients. The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey which showed the majority of patients were happy with the care they received. We also saw a survey of patient's experience of seeing the practice nurse team. The practice response to the surveys identified that more publicity for the appointment text reminder service and online services available to patients was required.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups. The PPG had carried out annual surveys and met every quarter. The practice had developed a virtual PPG to allow patients who were unable to attend meetings to comment on developments and receive news from the practice. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisal and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with told us they were able to ask for additional training to enhance their role and it was provided. For example we saw that training was funded for a practice nurse to complete a Diabetes Merit course. With this additional knowledge and skill the practice was able to run nurse led joint diabetes clinics from any location. This improved accessibility and outcomes for patients. There were very high levels of staff satisfaction at the practice. Staff were proud of the organisation as a place to work and spoke positively of the culture. There were consistently high levels of constructive staff engagement, with staff at all

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levels actively encouraged to raise concerns or suggest ideas. All staff we spoke with told us they felt they had the opportunity to raise concern or suggestion and praised the open and inclusive ethos of the practice.

The practice used innovative approaches to gather feedback from patients and the public. For example, the practice had its own social media applications including Facebook and Twitter. They used these applications to update patients about health promotions, services provided or any changes to the practice.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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.

The practice was an accredited GP training practice and also took medical students in year one, three and five. The practice had developed a positive reputation as a supportive location for GP Registrars to further develop their skills. We saw evidence of regular mentoring, training and feedback for GP Registrars and positive outcomes.

Discussions with staff and records showed that staff received continuous learning, training and an annual appraisal to develop their roles and improve outcomes for patients. The practice had a highly motivated staff team with extensive experience and skills, to enable them to deliver well-led services. High standards were promoted and owned by all staff.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. We saw that the practice included examples of good practice along with any concerns as significant events. For example a medicine was dispensed on repeat prescription after it had been removed from the electronic record by the GP. The investigation identified the patient had submitted a paper prescription form. The issue was discussed at clinical and reception meetings and the process for dispensing repeat medications amended.