Newgate Medical Group

Quality Report

Newgate Street
Worksop
Nottinghamshire
S801HP
Tel: 01909500266
Website: www.newgatemedicalgroup.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newgate Medical Group on 17 March 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should.

- Adhere to their recruitment policy when recruiting clinical and non clinical staff.
- Ensure all clinical staff are aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it.

Summary of findings

- Ensure all clinical staff should have a clear understanding of Gillick competencies.

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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with 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 evidence showed the practice responded quickly to issues raised, learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

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

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 outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles for the management of patients with long term conditions and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us 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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Summary of findings

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. 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.

The practice had told patients experiencing poor mental health about how to access various support groups for example the Improving Access to Psychological Therapies (IAPT) councillors. 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.

Summary of findings

What people who use the service say

In the most recent information from Public Health England 2013/14 showed 88% of people would recommend this practice to others and 76% were happy with the opening hours.

We received 27 completed patient CQC comment cards and spoke with six patients on the day of our visit. All the patient comment cards were positive about the care provided by the GPs the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs. However two patient comment cards mentioned they did not always get an appointment to suit themselves but did compliment the treatment they received from staff.

Patients told us the staff were very helpful, respectful and supportive of their needs. They felt all staff communicated well with them. They were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were given a caring service. Patients we spoke with said they would recommend the practice to other people.

Patients knew they could speak to someone in private if necessary. They were aware of the chaperone facility offered by the practice if personal examinations were undertaken.

The Patient Reference Group (PRG) was active and ensured they contributed feedback about patients' views. They told us they had conducted their own patients' survey in 2014 and contributed to the practices' patient event where they had a stall to promote the PRG.

Newgate Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Newgate Medical Group

The Newgate Medical Group surgery is located in Worksop. The building has good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services and is regulated to provide family planning, surgical procedures, treatment of disease, disorder or injury, diagnostic and screening procedures. The practice provides primary care services for 30,200 patients under a Personal Medical Services (PMS) contract with NHS England in the Bassetlaw Clinical Commissioning Group (CCG) area. The PMS contract is a contract between a general practices and NHS England for delivering primary care services to local communities.

The majority of the patients fall within the 15-69 years age range. Sixty per cent of the patients have a long-standing health condition in comparison to the national average of 54%.

The practice has a mixture of male and female GPs consisting of ten partners, four salaried GPs, three advanced nurse practitioners, seven practice nurses and one health care assistant.

The practice is open from 8.30am to 6.30pm Monday to Friday and Saturdays from 8.30 am to 11.30am.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access out of hours service run by the CCG or via the NHS 111.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

Detailed findings

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 we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 March 2015. During our visit we spoke with a range of staff including the practice manager, two GPs, a nurse and two members of the reception staff. We also spoke with six patients on the day and three representatives from the Patient Participation Group.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 27 CQC patient comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management 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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these 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 how they reported, recorded and monitored significant events, incidents and accidents. There were records of significant events which had occurred during the last 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff which included receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed to us the system used to manage and monitor incidents. We tracked 19 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example in the event of a fridge failure. 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 practice manager to practice staff. Hard copies were also printed off and given to the GPs. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any which were relevant to the practice and where they needed to take action.

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 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.

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 on the looked after register.

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). Only nursing staff, had been trained to be a chaperone. Reception staff did not act as a chaperone if nursing staff were not available. Those who had undertaken internal training from the practice nurse understood their responsibilities when they acted as chaperones, which included where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and vaccine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a clear cold chain policy to ensure vaccines were stored within the required temperatures, it also described the action to take in the event of vaccines failing to be maintained within the minimum and maximum temperature ranges. The practice staff followed the policy.

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

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

All prescriptions were reviewed and signed by a GP 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.

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 updates. We saw evidence audits had been carried out over the last five years and any improvements identified for action 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 which included 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. 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, monthly testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings.) We saw records which 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 all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated 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. Any items found to be old or faulty was replaced immediately.

Staffing and recruitment

Records we looked at contained evidence some recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which set out the standards it should have followed when they recruited clinical and non-clinical staff. However we did not see any references with respect to staff they had recently recruited. This showed to us they were not following their recruitment policy, we discussed this with the lead GP who agreed to rectify it immediately.

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 enough

Good

Are services safe?

staff were on duty. There was also an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave. The practice did not use locum doctors.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies 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 included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from a risk assessment on water hygiene.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available this included 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 it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were 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 mitigating 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. All the GPs had a copy of the business continuity plan.

The practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records showed staff were up to date with fire training, had nominated fire marshals and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (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 these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We saw evidence of the clinical meeting minutes which confirmed this had happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which were not as good as similar practices. The GP explained how they had identified the trends and what measures they had since put into place. The GP acknowledged there was still more work to done but they were heading in the right direction. The practice had also completed a review of case notes for patients with atrial fibrillation, diabetes, flu vaccinations and those treated with a bone-sparing agent. The evidence we saw showed patients were receiving appropriate treatment and regular reviews. 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. This confirmed patients were reviewed by their GP according to need.

National data showed 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 referrals.

Discrimination was avoided when the clinicians made care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduled clinical reviews, and how they managed child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

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 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). Following the audit, the GPs carried out medication reviews for patients who were prescribed certain medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records which showed how they had evaluated the service and documented the success of any changes.

The practice showed us four clinical audits that had been undertaken in the last five years. Of these the audit for benzodiazepine was a completed audit where the practice was able to demonstrate the changes which had resulted since the initial audit. Other examples included audits to confirm the GPs who undertook antibiotic prescribing, coil insertion and atrial fibrillation were doing so in line with their registration and National Institute for Health and Care Excellence guidance. The result of the atrial fibrillation showed 626 patients of which 403 were on aspirin and 7 on warfarin. When it was rechecked two years later it showed only 15 patients received aspirin.

The practice also used the information collected for the QOF and performance against national screening

Good

Are services effective?

(for example, treatment is effective)

programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met most of the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients who received repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance had been used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm, after receiving an alert; the GPs had reviewed the use of the medicine in question. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in how they provided training for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, osteoporosis and falls, moving and handling. Those with extended roles for example those who saw patients with long term conditions such as asthma, **Chronic obstructive pulmonary disease** (COPD), diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Staff files we reviewed showed where poor performance had been identified appropriate action had been taken to manage this. We saw evidence of this in the case of a member of the clinical staff.

Working with colleagues and other services

The practice worked with other service providers to meet individual patient's needs and manage those 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. The practice outlined the responsibilities of all relevant staff in how they passed on, read and acted on any issues from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. 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 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 referrals last year through the Choose and

Good

Are services effective?

(for example, treatment is effective)

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 this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

We found some staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The majority of clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. However we thought some of the clinicians were not fully aware of the legislation.

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. When interviewed, some staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The majority of 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). However some clinicians were not familiar with the application of this legislation.

There was a practice consent form where clinicians documented consent for specific interventions. For example, for all minor surgical procedures, cryotherapy and joint injections. A patient's written consent was obtained and documented with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice offered a health check with the health care assistant / practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they offered smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of how they identified patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check. Similar mechanisms identified 'at risk' groups, these were used for patients who were obese, epileptic, strokes or those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 77%, which was just below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Those who did not attend were followed up by a practice nurse.

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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 for 2014a survey of 108 patients and a survey undertaken by the practice's patient reference group (PRG). The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 90% of patients rated the practice as good or very good. The practice was also questioned for its satisfaction scores on consultations with doctors and nurses with 97% of practice respondents saying the GP was good at listening to them and 97% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments mentioned they did not always get appointments that suited them. We also spoke with six 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 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 patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when they discussed patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced for more book on the day appointments as they were booking too many routine pre bookable appointments in advance. Two GPs were on emergency surgeries for the book on the day and they found this gave them 100 appointments to give out on the day.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent complaint which showed appropriate actions had been taken.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us the displaying of this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and 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 translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available not only in English but also in Polish.

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 with said they had received help to access support services to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with this information. For example, these highlighted 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 saw information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). These included posters which advised patients to ask receptionists if they felt a more private conversation was needed. There was also a PRG display board which advertised for more patients to be on the PRG and also to display the number of those who did not attend for appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. These included patients with long term conditions, mental health conditions, families and children, older patients and working age patients.

The practice had access to online and telephone translation services. The practice provided equality and diversity training. Staff we spoke with and records we saw confirmed they had completed the equality and diversity training.

The premises and services had been adapted to meet the needs of patient with disabilities there was a ramp at the front of the premises and a bell was in situ so patients could press it to alert staff who would assist in any way they could.

The practice was situated on the first and second floors of the building with most services for patients on the first floor. There was lift access to the first and second floors. The practice was suitable for those who had mobility issues and used wheelchairs. This aided movement around the practice and helped to maintain patients' independence.

We saw 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.

The practice had a high population of English speaking patients though it could cater for other different languages through translation services.

Access to the service

Appointments were available from 8:30 am to 6:30 pm on weekdays and 8:30 am to 11:30am on Saturdays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 two local care homes by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed 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 patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

The practice's extended opening hours on an evening and Saturday mornings was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

We saw information was available to help patients understand the complaints system at the practice and on their website. 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 eight complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, there was openness and transparency in their dealings with the complainant.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the practice booklet. The practice mission statement, vision and values included to provide the highest quality health care available under the NHS. Patients will be treated with courtesy and consideration by all staff and will receive appropriate information about their treatment.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

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

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with six 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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. This was evident from our inspection on the antibiotic prescribing audit.

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

Leadership, openness and transparency

We saw from minutes team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted the practice had team away days. These were usually at Christmas and in the summer.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy which was in place to support staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We reviewed a report on comments from patients between 2012 and 2014, which had a common theme of the practice requiring decorating and new seats in the waiting room. The practice manager showed us improvements had been made to the practice even though it is an old building, which included new chairs and redecoration.

The practice had an active patient reference group (PRG) which had remained constant in size. The PRG included representatives from various population groups; in particularly the patients in the over 50's age group. The PRG had carried out surveys and met every month. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff away days for example a staff outing to Clumber Park, and more generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and

Are services well-led?

Good

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

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings which ensured the practice improved outcomes for patients. Examples included patients who had been commenced on diabetic medication and new instructions for cervical screening.