Lombard Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lombard Medical Centre on 16 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive, caring and well led services. It was good for providing services for older people, people with long term conditions, families, children and babies, working age people (including those recently retired), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Systems were in place for the learning and improvement from safety incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Learning from incidents was shared widely. Risks to patients were assessed and well managed
- A multi-disciplinary approach to patient care was evident; the practice worked well with other agencies to ensure care and support was coordinated.
- 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 training planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment but raised concerns about access to appointments.
- Information about how to make a complaint was available and easy to understand. Complaints were dealt with appropriately and in a timely manner
- 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.
- There was a strong commitment to quality within the practice and we saw evidence of a robust quality system.

We saw several areas of outstanding practice including:

Summary of findings

- The practice employed a pharmacist three days per week to provide a consultation and advice service. The pharmacist's role involved carrying out medicines audits, reviews of patients' medicines and offering clinics to see patients. The pharmacist was a trained prescriber and provided support to the nurse prescribers within the practice. The work of the pharmacist enabled the practice to effectively implement evidence based prescribing across a range of therapeutic drugs with patients.
- The practice had worked closely with the local traveller community and the lead GP for this group had been involved in making an award winning TV documentary which was subsequently used as a training tool.

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. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated internally and externally to support improvement. There were enough staff to keep patients safe. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

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. The practice's performance for the prescribing of antibacterial items and hypnotics was better than the national average.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were generally assessed and care was planned and delivered in line with current legislation. The practice demonstrated good outcomes and performance in respect of the quality outcomes framework (QOF) but had high exception reporting rates across a number of conditions. (The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF). Practice supplied data indicated this had reduced in 2014/15.

Staff worked with other health care professionals to improve patient outcomes. Regular multi-disciplinary meetings were held and actions identified. Staff had received relevant training, appropriate to their roles and training needs were regularly reviewed. There was evidence of appraisals and personal development plans for staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients spoken with on the day of the inspection said they were always treated with dignity and respect and they felt involved in their care and treatment. 94% of respondents said the last nurse they saw or spoke to was good at listening to them (the CCG average was 92%). Completed comment cards we received were all positive about the way in which they were treated by practice staff.

Summary of findings

The practice had systems in place to identify and support carers, including a Carers' Champion who sought to identify carers and provide them with information to support them in their role.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and planned services in accordance with this. For example the practice provided four extended hours sessions each week.

Patients we spoke with told us it was sometime difficult to contact the practice by telephone or get an appointment. This was supported by patient survey data. The practice were fully aware of patients concerns regarding access and were working to address these issues. For example the practice had implemented SMS messaging for patients to enable them cancel appointments without having to telephone the practice.

The practice had an active patient participation group (PPG) who told us about improvements the practice had made in response to identified priorities. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and values and staff were aware of these. The practice was working on developing plans for the future, for example consideration was being given to merging or federating with other nearby practices. There was a clear leadership structure within the practice and staff felt well supported by management. The strong leadership at the practice had been recognised through a number of achievements they had made. For example, the practice had received the RCGP Quality Practice Award in 2011 which was valid until 2016.

The practice had a robust quality system including policies and procedures to govern activity and held regular meetings, including 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) worked with the practice to identify areas for further improvement. Staff had received comprehensive inductions, regular performance reviews and attended staff meetings and events. Staff had access to appropriate training.

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.

All patients over 75 had a named GP for continuity of care. The practice was responsive to the needs of older people, and offered home visits for those with enhanced needs. Some services were offered within the practice to minimise travel for older patients, such as phlebotomy (collecting blood samples for testing). The practice had an enhanced care register.

The practice had designated GPs with responsibility for specific care homes and tried to visit these proactively. This enabled the GP to be aware of any issues within the home and aid continuity of care. The practice had a Carers' Champion who identified and met with carers to signpost them to local support services.

The practice employed a pharmacist who undertook medication reviews for patients and managed the system for repeat prescriptions.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had clinical leads for long term conditions.

We found that practice nursing staff had the skills and knowledge to respond to the needs of patients with diabetes, asthma, COPD and cardiovascular disease. The practice operated a robust call and recall system and had consistently achieved high QOF points. For example the published data showed that 80.4% of patients on the asthma register had received an asthma review in the preceding 12 months. This was 2.2% above the CCG average and 4.9% above the national average. The practice had high exception reporting rates across a number of conditions.

If patients were unable to attend the surgery, practice nurses and GPs undertook home visits. For those who attended the surgery for appointments, these were offered with flexible times and days.

The practice was aware of patients at risk of an unplanned admission to hospital and demonstrated a multi-disciplinary team approach to care planning. The practice had care plans in place for 2.22% of patients most at risk of a hospital admission.

Families, children and young people

Good

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

Summary of findings

There was a named safeguarding lead at the practice. The staff we spoke with demonstrated knowledge and understanding in relation to safeguarding children and were aware of their responsibilities to report concerns. The practice held regular meetings with health visitors and school nurses to discuss children at risk. The practice offered a service to fit contraceptive implants. Antenatal clinics and baby weigh in clinics were run from the practice by the midwives and health visitors. Midwives are based from the same site as the practice which aided communication.

Flexible appointment times were offered for mothers at the beginning and end of the day to avoid long waiting times. The practice had consistently achieved 90% rates for childhood immunisations.

The practice offered baby changing facilities, a secure pram park and an area where mothers could breastfeed should they not wish to do this in the main waiting area.

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 four extended hours sessions each week. Pre-bookable appointments were available up to two weeks in advance with GPs. The practice offered telephone consultations and telephone triage.

The practice was proactive in offering online services as well as a range of health promotion and screening that reflected the needs of this age group. The practice used technology and IT to communicate with this population group. For example, the practice sent out appointment reminders via text message.

The practice offered NHS health checks to patients aged 40-75. During flu season the practice offered a flu vaccination clinic on a Saturday morning to facilitate access.

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.

Summary of findings

The practice recognised patients whose circumstances may make them vulnerable, for example those who had no fixed abode or those who experienced drug and alcohol misuse. The practice reception staff were able to explain how they would register a patient of no fixed abode.

The practice had worked to build links with the local traveller community and had a lead GP who had previously run traveller clinics. The lead GP had been involved in making an educational health DVD with the travelling community.

The practice had a hearing loop and two members of staff could communicate using British Sign Language.

The practice had a significant number of patients for whom English was not their first language. Practice staff accessed translation services and had a good deal of information in a range of languages to ensure these patients were supported.

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). 96.4% of patients with a mental health condition had a comprehensive, agreed care plan in place.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a lead GP for mental health. The practice offered longer appointments for patients experiencing poor mental health as required and offered home visits for those patients unable to attend the surgery.

Summary of findings

What people who use the service say

We looked at the results of the national patient survey from July 2015. Questionnaires were sent to 381 patients and 129 people responded. This was a 34% response rate. The practice performed well when compared with others in the CCG respect of the following areas;

- 77% of respondents said they usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 65% and a national average of 65%;
- 74% of respondents said they were satisfied with the surgery's opening hours compared with a CCG average of 71% and a national average of 75%;
- 89% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 86% and a national average of 85%.

The practice did not perform as well in the following areas;

- 39% of respondents said that they found it easy to get through to this surgery by phone compared with a CCG average of CCG average of 66% and a national average of 73%;
- 38% of respondents with a preferred GP said that they usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%;
- 47% of respondents described their experience of making an appointment as good compared with a CCG average of 71% and a national average of 73%.

We reviewed comments from NHS Choices. The rating for the practice was four stars out of a possible five. There were 20 reviews left in the last 12 months. The reviews were mixed; 12 of the reviews referenced issues with access to appointments.

The practice was aware of areas for improvements and worked with the patient participation group (PPG) when considering how to improve access to and availability of appointments. A PPG is a group of patients who work together with the staff to improve the care to patients.

We received eight completed comment cards. These were all positive. Common themes included helpful and pleasant staff and an efficient service.

We spoke with five patients, two PPG members and a patient advocate on the day of our inspection. Patients we spoke with were long term patients of the practice and were generally very positive about the practice. Patients told us they found the practice clean and tidy and the staff welcoming. Patient said they did not feel rushed and were treated with dignity and respect. Most patients we spoke with reported there were difficulties with access to the practice and the availability of appointments.

We spoke with the chair of the PPG and the PPG secretary. They told us the practice engaged with the PPG and representatives from the practice attended the PPG meetings. They found the practice responded to suggestions for improvements.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice employed a pharmacist three days per week to provide a consultation and advice service. The pharmacist's role involved carrying out medicines audits, reviews of patients' medicines and offering clinics to see patients. The pharmacist was a trained prescriber and provided support to the nurse prescribers within the practice. The work of the pharmacist enabled the practice to effectively implement evidence based prescribing across a range of therapeutic drugs with patients.
- The practice had worked closely with the local traveller community and the lead GP for this group had been involved in making an award winning TV documentary which was subsequently used as a training tool.

Lombard Medical Centre

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 specialist practice manager, a specialist practice nurse and a CQC inspector.

Background to Lombard Medical Centre

Lombard Medical Centre provides primary medical services to approximately 18000 patients through a general medical services contract (GMS). Services are provided from a single location.

The practice is situated in Newark town centre. The practice population live in an area of deprivation which is similar to the national average but income deprivation affecting children is above the national average.

The clinical team comprises nine GP partners, a salaried GP, a GP retainer (GP retainers are employed by practices to work between one and four clinical sessions per week to maintain and develop their skills in general practice), a pharmacist, a practice nurse team leader and six nurses. This equates to a whole time equivalent of approximately 8.25 GPs and 5.27 nursing staff. The pharmacist works 27 hours per week.

The management team comprises a practice director, IT manager and office manager. They were supported by 26 staff including reception and administrative staff.

The practice is both an accredited training and teaching practice. At the time of our inspection there were three doctors in training based at the practice until December 2015.

The practice reception is open between 8.00am and 6.30pm Monday to Friday. Appointments are offered between 8.00am and 6.00pm on Mondays and Fridays. The practice offered appointments from 7.00am on Tuesdays, Wednesdays and Thursdays. On alternate Wednesdays and Thursdays appointments were offered until 7.30pm. The practice has a triage nurse available most mornings between 8.30 and 11.00am.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Central Nottinghamshire Clinical Services (CNCS) when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

We carried out an announced inspection of Lombard Medical Centre on 16 July 2015. As part of this inspection we received and considered pre-inspection information from the provider and had contact with the care homes the practice provided a service to.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before inspecting, 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 inspection on 16 July 2015. During our inspection we spoke with a range of staff including GPs, nursing staff, the practice pharmacist, the practice director, the quality manager and administrative staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety such as reported incidents and national patient safety alerts as well as comments and complaints received from patients. Learning from these was shared with staff at practice and clinical meetings.

Staff we spoke with knew how to report incidents and near misses using the forms available on the intranet. We saw evidence of a significant event which was flagged to the practice director by reception staff concerning the telephone system not working. The practice also had systems in place to flag and record information governance issues such as mistaken patient identities and we saw evidence of discussion of these issues at the monthly information governance meetings.

Safety records, incident reports and minutes of meetings for the last three years indicated 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 for reporting, recording and monitoring significant events. We reviewed records of 29 significant events that had occurred since 1 April 2014 and they were completed in a timely and comprehensive manner. Appropriate action had been taken to address the concerns and where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. We noted a range of issues identified as significant events such as concerns in respect of communication with outside agencies, specific medical diagnosis and medication review.

There was evidence that the practice had reflected and learned from significant events and that the findings were shared with relevant staff. The practice held significant event meetings every six to eight weeks and a dedicated meeting was held each year in April to review actions from past significant events and complaints. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and were encouraged to do so.

There was a system in place for reviewing national patient safety alerts (NPSA). These were received electronically and disseminated to the most appropriate members of staff. Minutes of staff meetings confirmed this. Medicines alerts were received by the IT manager and sent to practice pharmacist who reviewed these and forwarded them to the appropriate members of clinical staff. For example new prescribing guidelines for metoclopramide (medication used to treat nausea and vomiting).

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. 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 in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. 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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, midwives and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. 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. Chaperone duties were undertaken by reception staff and records reviewed showed they had received relevant training. Staff we spoke with understood their

responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a system to ensure that medicines were kept at the required temperatures. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice was performing well in respect of spend on medications and had a 7% underspend against its budget.

There was a system in place for the management of high risk medicines such as methotrexate (a drug which interferes with the growth of certain cells of the body) and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) e.g. morphine (a strong painkiller used to relieve severe pain). Controlled drugs were stored in a controlled drugs cupboard and access was controlled by the practice pharmacist. The GPs were also key holders. The practice had a policy in place which set out how controlled drugs were managed. One GP partner carried morphine in his medical bag. This was stored securely and appropriately and the practice pharmacist maintained spreadsheets for expiration dates of all medication carried by doctors.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance and these were up to date. Nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Two members of the nursing staff were qualified as independent prescribers and they both received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

The practice employed a pharmacist three days per week. The pharmacist was a qualified independent prescriber and provided a consultation and advice service to patients, holding clinics two days per week. The pharmacist undertook medication reviews, medicines audits and provided advice and guidance to the nurse prescribers.

Cleanliness and infection control

The premises to be clean and tidy and there were cleaning schedules 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.

An infection control policy and supporting procedures were available for staff to refer to. There were adequate stocks of personal protective equipment including disposable gloves and aprons 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.

The practice nurse team leader was the lead for infection control and 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 regular updates. The lead had carried out audits and improvements were completed on time. Minutes of practice meetings showed that the infection control was discussed.

Good

Are services safe?

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 which can contaminate water systems in buildings).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 which was 11 May 2015. 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

The practice had a recruitment policy. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and leave was covered. Occupational health checks were undertaken for new employees and there was ongoing access to occupational health for staff as and when this was required.

Staff told us there were always enough staff on duty to keep patients safe. The office manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had a health and safety manager whose responsibility was to ensure a safe environment. COSHH assessments were in place for all cleaning items and fluids and cleaning audits.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a health and safety policy and health and safety information was displayed for staff to see. There was an identified health and safety representative.

Risk were assessed and rated and mitigating actions recorded to reduce and manage the risk. The practice had asked an external agency to undertake a legionella risk assessment. This was comprehensive and we saw evidence that recommendations were being followed.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example nursing staff told us patients in the waiting area were monitored by reception staff and staff could raise an alarm if a patient needed emergency assistance, this alarm could be heard in all of the clinical rooms.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). All members of staff knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis and hypoglycaemia There were processes 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact

Good

Are services safe?

details for staff to refer to. The plan had recently been updated to include contact details for new staff. Two members of practice staff held a copy of this document off site in case of loss of access to the practice premises.

The practice had carried out a fire risk assessment on 17 March 2015 which included actions required to maintain fire safety. Records showed there were some outstanding actions such as staff training. Records indicated staff had last received fire safety training in February 2014 and that this was overdue. The practice director explained that they had recently started in the position and were reviewing training and ensuring that this was up to date. Fire training for staff had been arranged.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff 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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

NICE guidance was downloaded from the website and disseminated to staff. Minutes of clinical meetings demonstrated these were discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The GPs told us they led in specialist clinical areas such gynaecology, family planning, dermatology, diabetes and minor surgery supported by the practice nursing team and pharmacist to allow the practice to focus on specific conditions.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. The practice had identified those patients at risk of admission to hospital and had care plans in place for 2.22% of patients. Patients were followed up following discharge from hospital.

Data showed that the practice was performing better than the national average for prescribing in relation to antibacterial items and hypnotics. For example the average daily quantity of hypnotics prescribed for the practice was 0.08 compared with a national average of 0.28. The practice was underspent on their budget for 2014/15.

Management, monitoring and improving outcomes for people

Staff had key roles in monitoring and improving outcomes for patients. Staff had lead roles in a number of clinical areas specified in 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.

We reviewed two clinical audits which had been undertaken in the last two years. These were both completed audits where the practice was able to demonstrate a positive impact since the initial audit. For example the practice carried our an audit on patients with Type 2 diabetes receiving blood testing strips in line with national institute for health and care excellence (NICE) guidelines. This reduced the inappropriate prescribing of testing strips by over 50% over the two cycles of the audit.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. The most recently published data showed that it achieved 98.4% of the total QOF target in 2014, which was 3.1% above the CCG average and 4.9% above the national average. Specific examples to demonstrate this included:

- The practice achieved 99.9% of points available for diabetes related indicators which was 7% above the CCG average and 9.8% above the national average.
- 89.5% of patients with dementia had received a face to face review in the preceding 12 months which was 6.6% above the CCG average and 5.7% above the national average.
- The practice achieved 100% of available points for mental health related indicators which was 8.1% above the CCG average and 9.6% above the national average.

The practice's clinical exception rate (number of patients which are excluded by the practice when calculating achievement) within QOF was higher than the CCG and national average. Overall the practice had a clinical exception rate of 13.9% for 2013/14 which was 4.9% above the CCG average and 6% above the national average. We noted that this was significantly higher in some areas than others, for example:

- The practice exception rate in respect of the percentage of patients with a mental health condition who had a comprehensive care plan documented in the previous

Good

Are services effective?

(for example, treatment is effective)

12 months was 29.7% which was 8.7% above the CCG average and 16.4% above the national average. At the time of the inspection the practice had 156 patients on its mental health register.

Data provided by the practice (but not yet validated and published) showed that the clinical exception rate in respect of care plans for patients with a mental health condition had reduced in 2014/15. We noted that there were areas of higher exception reporting where patients were elderly and resided in care homes or were housebound. Evidence indicated that the practice was properly following the exception reporting process and they demonstrated that they had mechanisms in place to follow up patients who did not respond to recalls for appointments. We also saw that the practice had robust systems in place to ensure these patients received regular access to healthcare through home visits. We discussed with the practice that they could maximise the effectiveness of visits to patients by undertaking other health and wellbeing checks whilst there. This would help to ensure that the most vulnerable patients were in receipt of the necessary health checks to maintain their wellbeing and assist in reducing the practice's exception reporting rate.

The practice was aware of areas for improvement such as having a high A&E attendance rate. The practice A&E attendance rate per 1000 patients for 2014/15 was 459 compared with a CCG average of 343.5. The practice rate was the highest in the CCG area. Clinical staff told us they had a nearby minor injuries unit which was closer than the practice for a high number of patients. They explained that they were all working to educate patients and raise awareness of when patients should attend the practice rather than the minor injuries unit. The practice also had changed its appointments system to offer an increased number of same day appointments. They also offered triage and telephone appointments in addition to minor illness appointments.

The GPs and practice pharmacist provided supervision to the nursing team and the practice made use of appraisals, audits and staff meetings to improve quality and performance. Staff spoke positively about the culture within the practice around audit and quality improvement. They told us issues were regularly discussed at clinical meetings and there was a high level of professional engagement.

The practice's prescribing rates were better than national figures. For example the practice rate for prescription of hypnotics was 0.08 compared with a national rate of 0.28.There was a protocol for repeat prescribing which followed national guidance. The practice employed a pharmacist who led on all medicines management and was responsible for the practice's repeat prescribing system. The pharmacist was available to answer patient questions with regard to medication during set clinic times. The practice pharmacist also carried out medication reviews for patients. The practice had systems in place to ensure that all routine health checks were completed for long-term conditions such as diabetes. We saw evidence that changes in prescribing guidance and medicines alerts were disseminated throughout the practice.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Structured annual reviews were undertaken for people with long term conditions such as diabetes. Annual reviews for patients with diabetes were undertaken by the patient's GP.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice was performing in line with the CCG average of 87.9 per 1000 patients for non-elective emergency admissions. The practice ranked seventh out of fourteen practices in the CCG area in relation to this.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date with attending mandatory courses such as annual basic life support. There was a good skill mix among the doctors with one GP having an additional diploma in dermatology and one additional qualifications in family planning. 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

Good

Are services effective?

(for example, treatment is effective)

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).

The nursing team had a broad range of skills and experiences. For example, two of the practice nurses were nurse prescribers and two of the nurses were specialist nurse practitioners. Others had additional diplomas in areas such as diabetes, family planning and asthma. Nursing and medical staff were supported by the practice pharmacist who was a qualified independent prescriber. Administration and reception staff had been supported by the practice to undertake national vocational qualifications (NVQ) in areas including customer service and business administration.

All staff had received annual appraisals to identify learning needs from which action plans were documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice pharmacist told us they were supported to undertake prescribing qualifications. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. (COPD is the name for a collection of lung diseases)

Staff within the practice were given a range of opportunities to meet with their colleagues to discuss changes and updates. For example the nursing staff met weekly as well as attending a monthly clinical meeting. Reception and administration staff also met on a weekly basis and the practice had protected learning time sessions once per month.

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up. There was no backlog of correspondence to be actioned or scanned.

Emergency hospital admission rates for the practice were similar to the CCG average and the practice ranked seventh out of 14 for emergency admissions. Patients who were on the register for being at risk of admission had a flag on their patient records to ensure they are easily identified. When discharge letters are received these are sent to the relevant GP as well as an administrator. Patients are tracked to ensure follow up appointments are arranged as required.

The practice held multidisciplinary team meetings weekly to discuss patients with complex needs. For example, palliative care meetings and meetings to discuss patients at high risk of admission to hospital which were attended by GPs, practice nursing staff, administrative staff and external staff including district nurses, social workers, community matrons and occupational therapists. Care plans were shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers and had a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

Patients who were referred to hospital in an emergency had a summary record to take with them to A&E. The practice had signed up to the electronic Summary Care Record and this was fully operational. (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 was signed up to receive new patient information electronically from their previous GP through the GP2GP system. This system ensured that the practice received new patient information more quickly, but staff highlighted challenges they have seen with receiving information from other providers. For example they noted that there had been instances of missing or incorrect information on patient records and they had been working both to correct this and raise the issue externally.

Good

Are services effective?

(for example, treatment is effective)

The practice told us they were committed to ensuring that confidential patient information remained confidential. All staff within the practice received regular information governance training with annual refresher training.

Consent to care and treatment

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. There was a consent policy which highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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. Practice data showed that 89% of care plans for patients on the dementia register had been reviewed in the last year.

Verbal consent was obtained for minor surgical procedures in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

The practice website had a range of general health and signposting information for patients including sections on making the most of medications, family health, minor illness and long term conditions. The practice waiting area had a wide range of information, including leaflets and posters, regarding various health conditions and healthy living.

Basic information about patient health was recorded at the point of registration which included weight, height, blood pressure and smoking status. The practice offered health check to new patients on an opportunistic basis. GPs were informed of any health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that the practice had undertaken 508 health checks in the last year which equated to 50% of their CCG set target. This was the same as the CCG average. Patients were followed up if they had risk factors for disease identified at the health check and that further investigations were scheduled.

The practice had ways of identifying patients who needed additional support for example, the practice had identified the smoking status of 77.4% of patients aged 15 or over and actively offered smoking cessation support and treatment clinics to 62.4% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example the practice had started offering patients the opportunity to participate in weight management clinics. Treatment was initiated by the GP and followed up by nursing staff.

The patient participation group (PPG) was engaged with promoting healthy living and was in the process of setting up a walking group for practice patients which was fully supported by the practice. The practice and the PPG were looking at how they could run health promotion events within the practice. The practice had a dedicated health promotion noticeboard within the patient waiting area which was a new initiative. The first month had focused on being safe in the sun and the feature at the time of the inspection was around memory and dementia awareness.

Data from Public Health England showed that practice's performance for the cervical screening programme was 68.2%, which was below the national average of 74.3%. The practice followed up patients who did not attend for screening. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. Data from Public Health England showed that the uptake for bowel and breast cancer screening amongst practice patients was similar to the national average. For example 58.7% of eligible patients were screened for bowel cancer in the last 30 months compared with a national average of 58.3%.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Data indicated that the practice's performance was similar to the national average in respect of flu vaccination rates.

For example, Flu vaccination rates for the over 65s were 49.39% compared with the national average of 52.29%, and at risk groups 76.25% compared with the national average of 73.24%.

The practice was performing at a similar level to the CCG average in respect of childhood immunisations. The practice had consistently achieved over 90% for nearly all age groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We considered national patient survey from July 2015, feedback from the friends and family test and a survey of 224 patients undertaken by the practice's patient participation group (PPG). This data showed that the majority of patients were satisfied with how they were treated but the practice was rated slightly lower than the CCG average in a number of areas. For example in relation to its satisfaction scores for doctors:

- 83% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 85% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 87% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 92%

Patient satisfaction scores for nurses were the same as or better than the CCG and national averages:

- 94% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 90%.
- 94% said the nurse gave them enough time compared to the CCG average of 94% and national average of 92%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%

CQC comment cards 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. We also spoke with five patients and a patient advocate in addition to two PPG members 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. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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. Only one patient at a time could approach the reception desk which prevented patients overhearing potentially private conversations between patients and reception staff.

We observed members of the reception team treating patients with respect, dignity and compassion. For example a mother was breastfeeding in the reception area, reception staff noted this and went to give information to the patient rather than calling her to the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the majority of patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice was not rated as well as other practices in the local CCG area. For example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 81%.

Performance in these areas for nurses was the same as or better than the CCG and national averages:

- 91% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.
- 89% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

Patients 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.

Good

Are services caring?

Staff told us that 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 and guidance was available for staff on how to access these services.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed indicated that the majority of patients were positive about the emotional support provided by the practice and rated it well in this area. The ratings for GPs were slightly below the CCG and national averages:

- 82% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

A member of the reception team acted as a carers' champion within the practice. Patients identified as having caring responsibilities were offered information packs and booklets produced by the local council. There was a folder of information available in reception to assist with signposting carers to available support. GPs also took forms to record carers' details when on home visits. The practice invited carers for annual influenza vaccinations. Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and offered a range of enhanced services, for example invasive minor surgery, implant fitting and travel vaccinations. The practice also provided a range of clinics for the management of long term conditions such as asthma, heart disease, diabetes and chronic obstructive pulmonary disease (COPD). (COPD is the name for a collection of lung diseases). The practice did not run set times for these clinics which was especially helpful for working age patients who constituted the majority of the population. The practice pharmacist undertook regular patient medication reviews to ensure patients were taking the correct medication.

In addition the practice offered clinics such as well women, contraception, baby and childhood immunisations and yellow fever monitoring. The practice ensured that appointment for clinics were offered at convenient time for patients. For example working mothers could bring children for immunisations at the start or end of the day to minimise impact on their working day.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had been involved with a pilot project to improve access to urgent care and make general practice more sustainable. This involved the use of emergency care practitioners to attend home visits for unwell patients. Benefits identified included increased availability of GP time and more timely visits. Recommendations have been made for the service to be continued in the local area.

We saw minutes of meetings where provision of services was discussed and these evidenced the practice's willingness to provide additional services. For example, the partners had decided to express interest in providing 24 hour ECG monitoring (test to monitor heart rhythm over a period of 24 hours or more) and a mircosuction (an examination and treatment of the ear) service.

The practice was seeking to adapt the way in which it communicated with its patients. For example, the practice offered online booking for appointments and an online repeat prescription service. The practice had signed up to a service to enable SMS messaging to its patients with the aim of reducing the number of patients who missed appointments.

We saw evidence that the practice had adapted their service in response to their patient demographic. In recent year the number of patients registering with practice who did not have English as a first language has increased. The practice had ensured that it had information available in reception and on the practice website in a range of languages. The practice also had templates for standard treatments such as baby vaccinations in commonly spoken languages.

We saw evidence that practice had worked hard to build trust with the local traveller community. The practice had been involved in the development of a health passport for travellers which they would be able to take elsewhere if they left the area. One of the GP partners had run a travellers clinic and had also worked with a travellers' charity that promoted better health within the travelling population to produce an award winning documentary which was subsequently used as a training tool. The practice's performance in respect of childhood vaccinations and immunisations was evidence of continued engagement with this community.

Tackling inequity and promoting equality

The practice was situated in purpose built premises. There was a spacious waiting area with access enabled toilet facilities, baby changing facilities and a secure pram parking area. A room was available off the main waiting area for breastfeeding mothers or for confidential discussions if required.

The practice had recognised the needs of different groups in the planning of its services. For example, support for carers, longer appointment times for patients with learning disabilities and mental health, services for travellers and people whose first language was not English. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if required. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. For example we spoke with a patient advocate on the day of the inspection who felt that the practice treated patients with dignity and respect.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patient check-in screens were dual language for English and Polish and the practice had literature available in a range of languages. On the day of the inspection we observed the registration of two new patients who did not have English as first language and saw staff communicated well with these patients. The premises had a hearing loop and had two members of staff who were trained in basic sign language.

Staff told us patients that were of no fixed abode would be registered with the practice to enable them to access services as required. The practice had systems in place to flag vulnerable patients in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice had provided equality and diversity training for most staff and further training was planned for September 2015. We saw evidence that staff also covered some aspects of equality and diversity at a recent training session on how practices could be more accessible for families with disabled children.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. Appointments were available from 8.30am to 6.00pm Monday and Friday; from 7.00am on Tuesday Wednesday and Thursday and until 7.30pm on alternate Wednesdays and Thursdays. Appointments could be booked two weeks in advance for GPs and four weeks in advance for nurses.

Comprehensive information was available to patients about making appointments on the practice website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were regularly made to local care homes and to those patients who needed one.

The patient survey information we reviewed showed patients provided mixed responses to questions about access to appointments. For example:

- 74% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 47% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 77% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national averages of 65%.
- 39% said they could get through easily to the surgery by phone compared to the CCG average of 66% and national average of 73%.

The practice were aware of issues in respect of patient access to appointments. Practice staff told us they had a number of long term GPs leave last year within a short period of time which presented challenges in respect of patients getting access to appointments. The practice told us that they had been working to improve communication and access.

A system had been set up to enable SMS messaging for patients meaning that appointments could be cancelled via text message rather than the patient having to telephone the practice. In addition to this, the practice and PPG had conducted appointment demand surveys in 2014 and 2015 and these had shown improvements in the number of patients being offered appointments. The practice had supported and trained nursing staff to undertake triage calls to patients. The PPG survey indicated that 82% of respondents had found the triage service very helpful, helpful or satisfactory.

When the survey was initially undertaken in 2014 this showed that 21.4% of patients who contacted the practice to book an appointment were not offered an appointment. When the survey was repeated in 2015, this number had significantly reduced to 7.2%.

Some of the patients we spoke with on the day of the inspection told us that it could be difficult to get through the surgery on the telephone.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns which was 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to help patients understand the complaints system including a patient leaflet, information in the practice and links to information about complaints on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with had made a complaint in the past and this had been resolved promptly and to their satisfaction.

We looked at 35 complaints received since April 2014 and found these were responded to in a timely way and were fully investigated. The practice reviewed complaints annually to detect themes or trends and the findings and lessons learned were discussed as at partner meetings and wider staff meetings. The practice held a quality audit review meeting annually in April and we saw evidence that complaints, and learning from these, were discussed in detail.

Staff we spoke with were aware of the complaints process and how to support patients to make a complaint.

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 practice vision within the practice's statement of purpose and contained within staff handbooks. We also noted the practice's statement of purpose and objectives were displayed around the practice in staff areas. Some examples of the practice aims were that they were committed to promoting the health of their patients by ensuring the appropriate provision of high quality health services; operating in a safe and professional manner and providing supporting and training for staff.

The practice director and GP partners told us that there had recently been significant change within the practice with GP partners and the previous practice director leaving. The practice director explained that their initial priority was to ensure that all of their current processes and procedures were up to date and they were delivering services as effectively as they could be. In addition to this they told us the practice was working to develop a business plan and strategy. They were also considering federating (working together with other practices more closely to share resources or expertise) or merging with other practices in the locality.

It was clear from conversations with clinical and administrative staff that they shared the practice aims and values and were committed to providing high quality care. Staff were all engaged with the practice and their aims and values. The practice had a large number of staff who were long term employees.

We saw evidence that succession planning was regularly discussed. Recent changes in staffing at the practice had been planned to mitigate any potential adverse impact on patients.

Governance arrangements

The practice had a quality manager in post who had responsibility for maintaining a comprehensive quality assurance programme within the practice. The aims of this programme were to promote the health of patients by providing a consistent quality service, to give support and training to GPs and other staff and to ensure that all administrative and clinical tasks were carried out effectively.

The quality system comprised a master policy manual and sets of comprehensive works instructions. Each set of works instructions presented a sequence of steps to execute a clinical or administrative task. These were supported by clinical quality guidelines and practice policies. Works instructions, policies, procedures and guidelines were all available in hard copy and electronically and staff knew how to access these. The practice comprehensively audited their systems annually and held a quality review management review meeting in April each year.

The practice's commitment to quality had been recognised and some of the notable practice achievement were:

- Quality Accreditation Scheme Level 1&2 (2010 and 2012)
- RCGP Quality Practice Award (2011-2016)

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 partner was the lead for safeguarding. Staff we spoke with 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 GPs and the management team took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. These included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly partners meetings and management meetings.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review

Are services well-led?

Good

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

patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example in relation to the risk from fire. The practice monitored risks on a regular basis to identify any areas that needed addressing.

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

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the whistleblowing policy and where it was located.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes the practice held a range of meetings on a weekly and monthly basis, including clinical meetings, partner meetings, management meetings and quality meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at meetings and confident in doing so and felt supported if they did. We also noted that team away days were held on a regular basis including an annual boat trip for staff. Staff said they felt respected, valued and supported by the management and the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG comprising of seven members who attended monthly face-to-face meetings as well as a virtual PPG group with 29 members. The PPG carried out annual surveys and worked with the practice to identify areas for improvement. The PPG had a dedicated section on the practice website and survey results and areas for improvement were available for the wider patient population to review.

We spoke with two members of the PPG and they were very positive about the role they played in improving quality and said they felt very engaged with the practice. In addition to the published identified improvement areas, the PPG told us they had been involved in looking at the rate of missed appointments for the practice and considering how they can help to reduce this.

We saw evidence that the practice had reviewed its results from the national GP patient survey and was aware of the areas which needed to be addressed. This was evidenced by the work they had undertaken with the PPG regarding access to appointments.

Staff told us the practice management were responsive to suggestions for improvements. For example in response to staff feedback about the use of new ECG equipment, the practice management agreed to allow longer appointments to be booked for these patients.

Management lead through learning and improvement

The practice had been accredited as a multi-professional learning organisation and hosted a wide range of learners such as school students on work placement, nurses in training and management students as well as employing apprentices.

The practice had an ongoing quality assurance programme in place which specifically aimed to: promote the health of patients by providing a quality service, ensure all clinical and administrative jobs are carried out efficiently and support the staff with training. This programme was overseen by a dedicated team of eight staff members who had all received audit training. A quality management review meeting was held in April each year where areas such as complaints and SEAs were reviewed and significant points noted.

Staff told us the practice supported them to maintain their personal development. We saw evidence that staff were well supported to take on additional roles and responsibilities within the practice. For example the practice pharmacist told us he had been supported by the

Are services well-led?

Good

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

practice to be a qualified prescriber. Staff files and conversations with staff indicated that staff received regular appraisals and that the practice encouraged learning and development. Staff attended monthly protected learning time training sessions.

The practice was committed to learning and development. This was evidenced by the fact that the practice was a teaching practice and a GP training practice. At the time of the inspection there were three GP registrars working within the practice. We spoke with one GP registrar who was extremely positive about the practice and the support which was offered by the management, GP partners, practice pharmacist and other clinical staff.

The practice was involved in research projects with the University of Nottingham and this was led by one of the GP partners. For example last year the practice was involved in a research study around Improving glycaemic control in diabetic patients.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example we saw evidence of a hospital letter having been sent to the practice with an incorrect diagnosis and the incorrect information being entered onto the patient record. The practice investigated the matter and communicated their findings to the patient and removed the information.