The 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 The Medical Centre on 17 November 2014.

Overall the practice is rated as good.

We found the practice to be good for providing safe, effective, caring, responsive and well led services for all the six population groups we inspected.

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 the GP or nurse with urgent appointments available the same day.
- The practice had good facilities to meet patient needs and was well equipped to treat patients.
- 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 also areas of practice where the provider should make improvements.

The provider should:

- Ensure that the practice policy relating to employment and disciplinary of staff is implemented consistently for all staff.

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- Ensure clinical meeting minutes contain sufficient detail of discussion held so that it is clear what action is required and by which individual as well as the resulting outcomes for patient care.
- Ensure a central risk log is held to ensure all risks are reviewed in a timely way – for example yearly infection control audits to protect people from the risk of infection.
- Ensure that the vision and values are clearly recorded and accessible to both staff and patients.

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, incidents and near misses within the practice. Information about safety was recorded, monitored, appropriately reviewed and addressed. However, managers were not always aware of the requirement to notify us of specific incidents and deaths. This was discussed with them and the practice completed the relevant Statutory Notifications after our inspection.

Lessons were shared with all staff when things went wrong to ensure shared learning and improvement in the delivery of patient care. There were suitable systems in place to keep people safe and safeguarded from abuse.

Risks to patients were assessed and well managed. This included in areas such as infection control, medicines management, health and safety. There were sufficient equipment and drugs to ensure staff were able to carry out their role and respond to foreseeable emergencies.

There were enough staff to keep patients safe. We received evidence post our inspection to demonstrate improvements had been made to ensure appropriate recruitment checks had been carried out on all staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients mental capacity where required and promoting good health.

Clinical staff referred to guidance from National Institute for Health and Care Excellence and the Clinical Commissioning group to assess and monitor the effectiveness patient outcomes. Nationally reported data showed most patient outcomes were at or above average when compared with other practices.

Staff had received training appropriate to their roles and any further training needs were 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.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

Patient feedback about care and treatment received was mostly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. They 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.

We observed positive interactions between staff and patients during our inspection; and saw that staff treated patients with kindness and maintained confidentiality. The 2013/14 NHS England national patient survey results showed practice respondents rated the practice in line with the national average for most aspects of their care.

Patients' emotional and social care needs were considered in their care and treatment; as well as care plans. Information to signpost patients to support services for carers and Age UK for example, were available in the waiting area and easy to understand.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered in a way that met the needs of the practice population. This included the practice engaging with the Clinical Commissioning Group (CCG) and NHS England to secure improvements to services where these were identified.

The care of people with long term conditions, people in vulnerable circumstances and older people were coordinated with voluntary agencies, charities and other health providers. Reasonable adjustments were in place to ensure accessibility of services to all of its patients.

Patients told us it was easy to make an appointment at a time that suited them. This included urgent appointments being made available the same day and routine appointments usually available within 48 hours.

The 2013/14 NHS England national patient survey showed high patient satisfaction levels with the appointment system and phone access; and this was above the national average.

The practice had good facilities and was well equipped to treat patients and meet their individual needs. This included a range of specialist clinics for long term conditions, minor surgery and extended hours for both registered and non-registered patients.

Summary of findings

Information about how to complain was available to patients and staff, and easy to understand. Complaints were listened to, responded to in a timely manner and improvements were made as a result.

The practice provided GP services to persons in supported accommodation; and staff we spoke with told us practice staff were quick to respond to patient care needs and provided good continuity of care.

Are services well-led?

Good

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

The practice was taken over by the current GP in November 2013; and records reviewed showed significant improvements had been made to overcome challenges related to information and workforce governance arrangements. This included reviewing and updating policies and procedures that governed both clinical and non-clinical activities within the practice, and establishing a new practice team.

The practice had a clear vision with values focused on delivering good quality care. Most staff we spoke with knew and understood their responsibilities in relation to achieving this practice vision. There was a clear leadership structure in place and staff felt supported by management.

There were systems in place to assess and monitor the service provision, and the practice performance. This included the use of clinical audits and data from stakeholders such as the Clinical Commissioning Group to drive improvements.

The practice proactively sought feedback from patients and staff which it acted on. The patient participation group (PPG) was actively engaged in developing the practice surveys with staff. Staff had received appropriate training, professional development, and appraisal and attended staff meetings.

There was a process in place to identify, understand and address risks. However this was not formalised into a central risk log.

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.

The practice offered proactive and personalised care to meet the needs of older people in its population. This included a range of enhanced services such as monitoring patients identified as risk of hospital admissions and those receiving end of life care.

The practice had made improvements in reducing hospital attendances and admissions for older people with multiple health needs; and this included regular review of patients listed on the risk of admission register.

The practice staff worked together with other health professionals such as falls and bones clinic, district nurses and the community matron. Monthly multi-disciplinary team meetings were held to ensure a coordinated approach to patients care and treatment. Care plans reviewed identified patients' needs, diversity and how risks would be managed. Staff worked closely with carers to ensure they received appropriate support to continue in their caring role.

The practice was responsive to the needs of older people, and offered home visits and emergency appointments for those with urgent care needs. Health promotion services such as annual NHS health check and seasonal flu vaccination were provided. Robust recall systems were in place to ensure older people attended their medical appointments and health checks. All patients had a named doctor which ensured continuity in care.

People with long term conditions

Good

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

We spoke with five patients who had a long-term condition and they reported being supported to manage their condition. This included regular reviews of their conditions and medicines; as well as being provided with self-help advice to manage their care.

The GP took the lead role in chronic disease management and was supported by a team of practice nurses and a health care assistant. The GP used nationally reported data and clinical audits to assess and monitor that patients received care in line with best practice guidance.

For patients with complex health needs, the GP worked with relevant health and social care professionals to deliver a

Summary of findings

multi-disciplinary package of care. This included joint diabetic reviews with the community diabetic specialist nurse and the respiratory integrated team. Specialist clinics for diabetes, falls and bones were held at the practice.

The practice was responsive to people's needs and offered home visits, emergency appointments for those with urgent care needs and longer appointments when required. There were emergency processes in place to refer patients whose health deteriorated suddenly; and delays in referrals were investigated to ensure patient received timely care.

All patients had a named GP and were offered a structured annual review to check that their health and medication needs were being met. The GP participated in a monthly multi-disciplinary meeting where patients at risk of hospital admission were identified as a priority and had care plans put in place.

Families, children and young people

Good

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

Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who failed to attend their childhood immunisations or baby checks.

Immunisation rates were relatively high for most standard childhood immunisations with the practice working towards improving pre-school booster vaccinations as this was below the Clinical Commissioning Group average.

Parents could access bi-monthly health visitor clinics and weekly midwifery clinics to ensure the health care needs of the children were met. We saw good examples of joint working with midwives, health visitors and school nurses. Appointments were available outside of school hours and the premises were suitable for children and babies.

Contraceptive services including coils and implants were available for mothers to access. There was an availability of health promotion for patients to access. Staff had received safeguarding and domestic violence training to support them in preventing abuse to patients.

Summary of findings

The practice was working towards “You’re Welcome” accreditation. The “You’re Welcome” programme was initiated by the Department of Health and sets out principles to support health service providers to improve the quality of their services and become more young people friendly.

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 had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Services offered included, extended opening hours on a Monday, telephone consultations and some online services.

These included online appointment booking and repeat prescription ordering. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group.

The practice also offered weekend opening hours on a Saturday to both registered and non-registered patients. The practice were contracted to provide community based electrocardiogram (ECG) monitoring services, ear syringing, phlebotomy as part of the Any Qualified Provider (AQP) scheme for example.

Any qualified provider (AQP) means that when patients are referred, usually by their GP, for a particular service, they should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.

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 asylum seekers, refugees, EU nationals whose first language was not English, people with a learning disability and patients with an offending history.

Reasonable adjustments had been made to reduce any barriers in accessing the service. This included providing interpretation services for patients who did not speak English and signposting patients to support groups and voluntary organisations relevant to their social care needs.

Summary of findings

The practice carried out annual health checks for patients with a learning disability and offered longer appointments during consultations. Staff regularly worked with multi-disciplinary teams in the case management of vulnerable people.

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 received an annual physical health check and a review of their care plans were completed to ensure they were receiving appropriate care. The practice was working towards improving the uptake of the physical health checklist (Physform) for those people accessing secondary mental health services.

Other services provided included referrals to community mental health teams when a patient's mental health needs increased and signposting patients to voluntary organisations such as MIND and those dealing with issues such as housing, financial advice and support into work. MIND is a national charity that provides advice and support to empower anyone experiencing a mental health problem.

A system was in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice was signed up to the dementia enhanced service for timely screening and diagnosis. Staff carried out advance care planning for patients with dementia. Staff we spoke with demonstrated awareness of the need to be empathic when supporting patients within this population group.

Summary of findings

What people who use the service say

We received seven completed Care Quality Commission (CQC) comments cards providing feedback about the service. We also spoke with seven patients and one representative of the practice's patient participation group (PPG) on the day of our inspection. All but one patient gave complimentary feedback about the service they experienced and had no complaints.

The key themes from patient feedback included the following:

- staff treated them with dignity and respect and were polite and helpful.
- the GP and nurses were caring, listened to their care needs and took appropriate action.
- phone access to the surgery was relatively easy with availability of appointments being made the same day on most occasions.
- prescriptions were processed within 48 hours and they received their medicines in time
- they were invited for regular reviews of their health and medicines; and
- they were treated in a clean and comfortable environment.

We looked at the practice's 2013 and 2014 patient surveys which also showed positive patient feedback. For example, the results of the practice's 2014 satisfaction survey showed:

- 90% of respondents stated the GP was good at giving them enough time for discussion during consultations,
- 85% felt the GP was good at involving them in decisions about their care and
- 94% stated the nurses were good at explaining treatments and tests.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure that the practice policy relating to employment and disciplinary of staff is implemented consistently for all staff.
- Ensure clinical meeting minutes contain sufficient detail of discussion held so that it is clear what action is required and by which individual as well as the resulting outcomes for patient care.
- Ensure a central risk log is held to ensure all risks are reviewed in a timely way – for example yearly infection control audits to protect people from the risk of infection.
- Ensure that the vision and values are clearly recorded and accessible to both staff and patients

The Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP and Practice Manager specialist advisor.

Background to The Medical Centre

The Medical Centre provides GP services from a single location to approximately 2000 patients in the New Basford area of Nottingham. The practice was taken over by Dr Khudija Irfan in November 2013, and is an individual GP practice.

The practice is located in an area of high deprivation where the life expectancy for men and women is 76 years and 81 years respectively; which is in line with the national average. The practice population is culturally diverse and comprises of 66.6% patients of white British, 16.7% of Black/African Caribbean patients and 16.7% of Asian – Indian/Pakistani/Bangladeshi patients.

The practice staff comprise of one full-time female GP, one part time health care assistant and three part time nurses. The clinical team is supported by a practice manager and an administration team of three staff, all of whom work part time.

The Medical Centre is a teaching practice for first, second and fifth year medical students. The GP is keen for the practice to become a training practice in the future and is working towards becoming a GP trainer.

The practice holds a Personal Medical Services (PMS) contract which is a locally agreed contract between NHS England and the GP practice. The practice provides a full range of essential, additional and enhanced services including child and adult immunisations, family planning, contraception services, minor surgery and monitoring of unplanned hospital admissions.

The practice has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided by Nottingham Emergency Medical Services – NEMS.

Why we carried out this inspection

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

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

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

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

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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the NHS England local area team and Clinical Commissioning Group. We carried out an announced visit on 17 November 2014. During our visit we spoke with six staff members including the GP, practice manager, health care assistant and administration staff. We also spoke with seven patients who used the service.

We observed how people were being cared for and talked with carers and/or family members. We reviewed examples of patient care plans to corroborate our findings about services provided. We reviewed seven comment cards where patients and members of the public shared their views and experiences of the service.

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. Records reviewed showed agreed actions and subsequent checks by management to ensure shared learning had been embedded and no further incidences had occurred.

We found the practice had been notified of the sudden death of patient by the coroner. A significant event was logged and records of the patient's care reviewed. However, the practice did not submit a formal Statutory Notification to the Care Quality Commission to inform us about this event as they are legally required to do. This was addressed following our inspection.

We found the practice worked to ensure staff safety. This included staff having access to a panic button to use in the event of an emergency or being accompanied by the community support officers during late evenings due to previous concerns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and accidents. We reviewed significant events that had occurred during the last 12 months and found appropriate action had been taken to address the concerns. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

There was evidence that staff learned from safety incidents and that findings were shared with all staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at team meetings and they felt encouraged to do so. Significant events were a standing item on the practice meeting agenda and actions from past significant events and complaints were reviewed at least annually.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. This included safeguarding policies and procedures which provided guidance for staff. Staff knew how they could access these polices if needed and were able to describe the process for reporting any safeguarding concerns. Training records reviewed showed all staff had received relevant safeguarding training specific to their job roles.

Staff knew how to recognise signs of abuse in older people, vulnerable adults, people with mental health needs and children. They were aware of their responsibilities in relation to: information sharing and maintaining appropriate records of the safeguarding concerns. Staff were aware of the external agencies to contact and raise their concerns. Contact details were easily accessible to them.

The GP was the lead in safeguarding vulnerable adults and they had attended level three child protection and safeguarding vulnerable adults training to ensure they were able to provide staff with appropriate support. The GP demonstrated good liaison with partner agencies and participated in child protection meetings held at least bi-monthly, with the practice nurse and health visitor.

The practice participated in red card meetings which reviewed safeguarding concerns related to families, children and young people. Recall systems were in place to follow-up on children who persistently failed to attend appointments for childhood immunisations and young people and families living in disadvantaged circumstances.

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, patients who needed to be seen by two clinicians due to identified risks to staff and those whose circumstances made them vulnerable.

The practice had a chaperone policy in place and this was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Are services safe?

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear cold chain policy for ensuring that medicines were kept at the required temperatures and this was followed by staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we looked at 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. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Records reviewed showed significant events linked to errors related to repeat prescriptions were addressed. We reviewed the policies and flowchart detailing the process of repeat prescribing and found them to be appropriate.

There was a system in place for the management of high risk medicines and repeat medications for patients with multiple medications. This included regular monitoring of patient's medicines in line with national guidance and appropriate action was taken based on the results. Staff were aware of how to raise concerns around drug errors and these were investigated as part of a significant event.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. This was also reflected in the 2013 patient survey results which showed 92% of the 30 respondents were satisfied with the practice cleanliness. Overall, we observed the premises to be clean and tidy. The practice had a refurbishment plan in place including replacing the carpet.

An infection control audit had been completed on 09 January 2013 and 03 March 2013 by a nurse from the local infection prevention and control team. A score of 94% had been achieved at the second visit with an action plan in place to address the 6% improvement areas. This included replacing the carpet in the waiting area with vinyl flooring and refurbishments were due to be funded by the Clinical Commissioning Group (CCG). We were told the CCG infection and control nurse had provided staff training on 07 November 2014 and had advised of plans to re-audit the practice within three months of this date. We saw cleaning schedules were in place and cleaning records were kept.

The practice had a clinical and non-clinical lead for infection control and they were responsible for monitoring infection control and prevention within the practice. These were the GP, healthcare assistant and the practice manager. Staff had received training about infection control specific to their role within the last 12 months.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

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 most treatment rooms. We saw records that confirmed the practice had requested for a Legionella risk assessment from an external company on 14 November 2014.

After our inspection we received confirmation that the assessment had been completed on 20 November 2014 with no concerns noted. Prior to this assessment, the practice had not always carried out checks to test for legionella in the water supplies 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 to ensure it was safe for use. We saw equipment maintenance logs to confirm this and a schedule of testing equipment was in place. This included portable appliance testing for all electrical equipment in September 2014 and stickers indicating the last testing date were displayed. We saw evidence of calibration of clinical equipment was completed in July 2014. This included weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and

non-clinical staff, including the pre-employment checks that should be carried out. We reviewed four staff files and found appropriate recruitment checks had not been undertaken prior to staff employment. We found incomplete documentation to evidence that the following checks were completed in line with the practice recruitment policy: two references, Hepatitis B immunisations for staff, risk assessments and / or criminal records checks through the Disclosure and Barring Service (DBS).

This was discussed with the provider during the inspection and we were provided with the identified missing documentation after our inspection. This assured the provider that staff were of good character, and were physically and mentally fit for work. We saw that the registration of clinical staff such as nurses and the GP were checked with their respective professional bodies to ensure they were competent to practice.

The practice manager told us about the arrangements in place for planning and monitoring levels of staffing to ensure they were responsive to patient demand. This included the use of a rota system for both clinical and non-clinical staff to ensure that sufficient staff were on duty when the practice was open. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Staff told us they had received appropriate induction and training to meet patient needs; and most staff files reviewed confirmed this.

There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. One of the GPs from neighbouring Greenfield Practice and a regular locum provided cover in the absence of the GP. Staff told us there were usually enough staff to maintain the smooth running of the practice and provide safe services for patients.

Monitoring safety and responding to risk

The practice had policies and systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and a variety of risk assessments had been completed. However, the practice had not detailed all the identified risks on a central risk log to ensure that each risk was regularly reviewed and rated.

We saw that risks were discussed at team meetings and control measures were agreed to minimise identified risks. For example, the findings from the practice's 2013 infection control audit had been shared with the team and most of the actions had been completed at the time of our inspection.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. This included: weekly fire alarm checks, fire drills with the most recent completed on 07 November 2014, servicing of fire extinguishers by the fire and rescue service, and fire safety training for staff. Records reviewed showed staff had received health and safety training.

We saw that staff were able to identify and respond to changing risks to patients including medical emergencies. For example there were emergency processes in place to make urgent secondary care referrals for patients whose health needs had deteriorated suddenly and needed specialist medical advice. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for patients receiving medication for mental ill-health.

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, and / or cardio pulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED is used to attempt to restart a person's heart in an emergency). Emergency equipment was available including access to oxygen and an automated external defibrillator. Staff we spoke with knew the location of this equipment and records confirmed it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions to reduce and manage the identified risks were recorded and the responsible person

for undertaking the agreed actions was named. Risks identified included loss of data, failure of utilities such as water and electricity, adverse weather and unplanned sickness or leave of absence. The document also contained contact details for staff and agencies to liaise with in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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 the Clinical Commissioning Group. NICE guidelines were readily accessible to staff from any practice computer and the GP received email updates on a regular basis.

We reviewed minutes of monthly clinical meetings held where patient care needs were discussed. Whilst the GP was able to give examples of guidelines disseminated and the implications for the practice's performance and patient support; this was not always recorded in great detail in the meeting minutes. This is an area the practice should improve on to ensure that all staff receive formal feedback on changes in clinical practice. This is particularly important given the practice nurses work on a locum basis pending the recruitment of a permanent practice nurse.

We found thorough assessments of patients' needs were completed in line with NICE guidelines, and these were reviewed when appropriate. For example, assessments related to patients with dementia, mental health needs and long term conditions.

The GP told us they were very open about asking for and providing colleagues with advice and support. There were monthly meetings held where complex cases were discussed with other relevant professionals. Interviews with staff showed the culture in the practice was that 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

Designated staff had key roles in monitoring and improving outcomes for patients. These roles included data input, managing the recall systems for patient health reviews, and clinical audits. The GP undertook regular clinical audit cycles to help improve the quality of services provided and to check that appropriate care and treatment had been delivered in line with evidence based practice.

The GP told us clinical audits were often linked to safety alerts, performance management data and / or 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.

For example, one audit looked at the number of patients with diabetes who had their cholesterol checked in the 2013/14 QOF year. The first audit demonstrated that 13 patients were found to have cholesterol levels of less than five and were not on the maximum dose of statins (cholesterol-lowering drugs that are frequently used as part of diabetes care) recommended by the British National Formulary (BNF). The BNF is a reference book for prescribing, dispensing, and administering medicines.

The practice made contact with all patients and reviewed the health needs of nine patients who had responded. A second clinical audit was completed which demonstrated an overall improvement with five patients having cholesterol levels higher than five at retest. Of the four patients that had cholesterol levels of less than five this was by a marginal amount so the GP felt it was not clinically appropriate to start them on statins.

The practice showed us five clinical audits that had been completed within the last 12 months. These audits included chronic kidney disease monitoring and treatment, patient diabetic control and patient attitudes to flu jabs. Following each clinical audit changes to treatment or care were made where needed and for two of these, the audits were repeated and showed outcomes for patients had improved.

The practice used the information collected for the QOF and quality and productivity (QP) indicators to monitor outcomes for patients. Records reviewed showed the practice had made effective improvements in reducing referrals to dermatology, audiology, trauma and orthopaedic secondary services by implementing locally agreed care pathways in line with best practice.

The GP 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. The practice also participated in local benchmarking run by the CCG. This is a

Good

Are services effective?

(for example, treatment is effective)

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice maintained a palliative care register and staff participated in monthly multi-disciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The practice was taken over by the current GP in November 2013 and one of the challenges faced was to establish a stable staffing team. The practice team included medical, nursing, managerial and administrative staff. The current nurses worked on a locum basis pending recruitment of a permanent practice nurse. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as basic life support and safeguarding children, and vulnerable adults.

We were told that all staff were required to complete an induction when they first started working at the practice. Whilst we found an induction form in most staff member's file, they had not always been fully completed. All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Our interviews with staff confirmed the practice was proactive in providing training and relevant professional development. Medical students training to be qualified doctors were offered learning opportunities as the practice was a teaching practice. Records reviewed showed positive feedback about the level of support and learning opportunities provided for medical students.

However, one staff file we looked at showed where poor performance had been identified appropriate action had not always been taken in line with the practice policy. The management acknowledged learning from the experience, and had sought support from an external organisation with their human resource processes. This was an area the practice had already identified as needing improvement. We requested the practice to complete a risk assessment retrospectively to ensure risks to patient care were minimised.

The GP told us they were up to date with their yearly continuing professional development requirements and had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and care of patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD). The locum practice nurses were supported by the community diabetes nurse specialist who facilitated monthly clinics.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. For example, if a patient was seen by the out of hour's provider, this was submitted to the practice via email, allocated to the GP to address and filed in the patient's notes. We checked the practice's pathology results mailbox and saw that all results had been actioned.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well. Incidences of urgent referrals and administration tasks not being processed timely were reviewed as significant events and learning was shared with staff to improve service delivery.

The practice was commissioned for the new enhanced service to follow up unplanned hospital admissions and

Good

Are services effective?

(for example, treatment is effective)

patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings each month 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 the practice manager, health visitor and nurses. 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.

After our inspection we spoke with one social care professional that worked with the practice and they described the GP as responding to patient concerns in an efficient and effective manner.

Information sharing

The practice used several electronic systems to communicate with other providers. These included Choose and Book, the electronic prescribing service and a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. (Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

The GP we spoke with demonstrated awareness of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

For some specific scenarios, where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, and for example with making 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 in response to changes in their health needs) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GP used their contact with patients to help

Good

Are services effective?

(for example, treatment is effective)

maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with mental health needs and learning disability; and all the patients were offered an annual physical health check. The practice also offered: weight management for obese patients, new leaf stop smoking service, NHS Health checks to all its patients aged 40 to 75 years men as well as well persons check for both men and women.

The practice's performance for cervical smear uptake was 85.7% which was above national average of 81.9%. 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. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. 2013/14 data showed 77.3% of patients aged 65 and older had received a seasonal flu vaccination, which was slightly above the national average of 73.2%.

The practice used the Quality and Outcomes Framework (QOF) and data from the Clinical Commissioning Group (CCG) to measure its performance and inform decision making related to clinical care. QOF is the annual reward and incentive programme detailing GP practice achievement results.

For example, in response to QOF data which showed pre-school booster vaccinations for the practice were low (65% in 2013), improvements had been made in 2014 with the practice having achieved 80%. These improvements were a result of the nurses and practice manager undertaking targeted work to improve the uptake of immunisations for two to five year olds. The practice was also working towards increasing uptake to 95% in line with the World Health Organisation recommendation.

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 2013/2014 national patient survey and a survey of 30 patients undertaken by the practice. The evidence from all these sources showed most patients were satisfied with how they were treated, and this was with compassion, dignity and respect. For example, the practice's own survey results showed all respondents felt the receptionists were helpful and 83% would recommend their practice to someone who moved in the local area.

In addition, data from the national patient survey showed 90.8% of respondents rated that the nurses were good or very good at treating them with care and concern and 80.3% related to the GP. The values related to the nurses were in line with the national average of 90.5%; however the value related to the GP was below the national average of 85.3%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and all were positive about the service experienced. Patients said they felt the practice offered a very good service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All but one 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. We observed consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was shielded by glass partitions which helped keep patient information private. In response to patient feedback, a separate room was available to ensure conversations between patients and reception staff were kept confidential. The practice had a chaperone policy in place. We saw notices in the waiting area and consultation room informing patients that chaperones were available for intimate examinations.

The practice had registered patients living in three supported housing schemes for people with mental health needs, ex-offending histories and recovering from drug and alcohol addictions. Practice staff were aware of the need to ensure these population groups were able to access the practice without fear of stigma or prejudice, and to treat them in a sensitive manner. It was the practice's policy to reduce any barriers to them receiving care and staff demonstrated sensitivity when describing how they provided support.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were aware of reporting instances of discriminatory behaviour or where patients' privacy and dignity was not being respected to the practice manager and / or GP.

Care planning and involvement in decisions about care and treatment

The results of the practice's 2014 satisfaction survey showed:

- 90% of the 30 respondents rated the GP was good at giving them enough time for discussion during consultations,
- 85% felt the GP was good at involving them in decisions about their care and
- 94% rated the nurses were good at explaining treatments and tests.

These positive responses were also reflected in the data from the 2013/14 national patient survey, although slightly lower percentages were achieved. 85.2% of respondents to the national patient survey described their overall experience of the GP surgery as fairly good or very good and this was in line with the national average of 85.7%.

The practice aimed to make patients partners in their own care, particularly those experiencing poor mental health and those with long term conditions. For example, the 2013/14 QOF data, showed 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months.

Good

Are services caring?

This compared positively to the national average of 86%. In addition, 100% of patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months; which was above the national average of 83.8%

All but one patient we spoke with said they were sufficiently involved in planning and decision making about their care and treatment; and rated the practice well in these areas. Patients told us their health needs were discussed with them and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They felt listened to and supported by staff. Patient feedback on the comment cards 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. This was confirmed by notices we saw in the reception areas informing patents this service was available. We saw five examples of care plans for individual patients within the following population groups: at risk of unplanned hospital admission, older person, mental health needs, learning disability and a patient receiving end of life care. The care plans demonstrated patient involvement in agreeing them.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with and the comment cards received showed staff responded compassionately when they needed help; and access to advocacy services was facilitated. The GP told us they spend time talking to the patient and / or their carer to help them understand their care, treatment and condition. This included making referrals for counselling services with a patient's consent. The practice assessed patients with long-term conditions and multi-health needs for anxiety and depression so as to provide appropriate support.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included carer support services, Age UK and counselling. The practice's computer system alerted the practice staff if a patient was also a carer. This prompted staff to consider the needs of the carer and provide support when required. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw that emotional needs of patients with learning disabilities and mental health needs were considered in assessment and care planning for example. There was shared decision making about the patients care and treatment. Patients were supported to be partners in the decision making of their care. For example, patients were encouraged to make self-referrals for physiotherapy, podiatry and talking therapy where appropriate as part of promoting self-care and independence.

Some staff we spoke with told us if a patient had suffered bereavement or was not coping emotionally with their health needs, they were telephoned or written to and invited to make an appointment. This call was either followed by a patient consultation at a flexible time, a home visit or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the individual needs of the practice population were understood and were central to the planning and delivery of services. This included the practice having an awareness of its local community and how factors such as deprivation, disability, social housing, diverse population culture and ethnicities would impact on demand for services.

For example, the practice is located in an area of high deprivation (36.55%) compared to the national average of 23.65%. These factors affected vulnerable patients such asylum seekers and refugees, EU nationals whose first language is not English, those receiving treatment for drug and alcohol addiction and mental health needs.

In response to the above, a coordinated approach to patient care and treatment was promoted to ensure the needs for these population groups were met. For example the practice worked with various multi-disciplinary professionals and voluntary organisations to ensure patients physical and emotional health needs were addressed. The patients also benefited from a continuity of care as they were seen by the same GP and regular nurses. Where required, patients were provided with letters of support related to their disabilities.

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 that needed to be prioritised. We saw reports evidencing the agreed actions to implement service improvements and manage delivery challenges to its population.

For example; the Quality Practice data for 2013/14 data showed improvements had been made in reducing gastroenterology admissions from 30 to three admissions after agreed actions had been implemented. Gastroenterology involves the diagnosis and management of patients with diseases of the intestines, liver, lbileary tree and pancreas (digestive system).

Emergency admissions for cancer patients remained high in comparison to the CCG average and the practice was reviewing reasons for this. The practice was also addressing concerns of bowel screening patients who did not attend appointments through its recall systems.

The practice offered a variety of services to meet all the different population groups we inspected. For example: specialist nurse clinics for long term conditions such as diabetes, bone health and respiratory problems; contraceptive services such as the depot, coil and implant for female patients; baby immunisations and midwifery clinics; smoking cessation and travel vaccinations.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included liaison with the local council regarding additional bin facilities to minimise litter dropping outside the practice.

Tackling inequity and promoting equality

The practice was committed to providing an accessible and welcoming service to all patients. This included providing staff with equality and diversity training to promote awareness of anti-discriminatory practice and social inclusion for example. Staff we spoke with gave examples of reasonable adjustments made to remove barriers for different population groups to access the service.

These included: access to telephone and face to face translation services for patients who did not speak English as a first language; hearing loop for patients with hearing impairments and flagging vulnerability in individual patient records. Most of the patient population spoke English and some practice staff spoke other languages such as Urdu and Punjabi. This was relevant as the practice population comprised of people of Asian origin.

People not registered at the practice were able to access appointments at the practice as it had been granted Any Qualified Provider (AQP) status. Any qualified provider (AQP) means that when patients are referred, usually by their GP, for a particular service, they should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations. Services provided as part of the AQP included electrocardiogram (ECG), ear syringing and phlebotomy. The GP told us they were proud for having secured funding for this service and were hoping to increase the patient list as a result.

We found the practice was responsive to patients care needs and systems were in place to maintain the level of services provided. For example, the registration process for asylum seekers, refugees and other vulnerable migrants

Are services responsive to people's needs?

(for example, to feedback?)

included referral to the Nottingham "into the mainstream" project. The 'into the mainstream' asylum seeker health project seeks to provide information, advice and practical assistance to help patients' access NHS health services.

Longer appointments for patients with learning disabilities, mental health needs or recovering from drug and alcohol addictions were also offered. This was to ensure sufficient time for consultations and completion of their annual health checks for example. Positive working relationships had been developed between the practice staff and support workers for patients living in supported accommodation close to the practice to ensure easy access of services.

The practice was situated on the ground floor therefore easily accessible to all patients. This included accessible toilet facilities and sufficient space within the waiting area to accommodate patients with wheelchairs, and pushchairs. The waiting area was also large enough to allow easy access to the treatment and consultation rooms.

Access to the service

The 2013/14 NHS England - GP patient survey results showed the practice was responsive in ensuring that patients could access appointments and services in a timely manner. For example, 95.1% of respondents gave a positive answer to the question "Generally, how easy is it to get through to someone at your GP surgery on the phone?" and 92.4% of patients were "very satisfied' or 'fairly satisfied' with their GP practice opening hours". These two percentages were above the national averages of 75.4% and 79.8% respectively".

These positive results were also aligned to the practice's 2013 survey results which showed patients were satisfied with the appointments system. For example, out of 30 completed questionnaires, 96% of the patients found it easy to access an appointment and 100% felt it was generally easy to get through to someone on the phone. All the patients we spoke with and comment cards received mirrored these findings. Patients told us they were able to access same day appointments and / or a telephone consultation if they needed to on most occasions.

We also reviewed the practice appointment system and found appointments were bookable six weeks in advance, and patients calling on the day could get an appointment within 48 hours. Appointments were usually scheduled for ten minutes with longer appointments offered when required. For example, the practice's electronic records system alerted staff if a patient needed a translator, had learning disabilities and / or mental health needs, so that the length of appointment could be tailored to meet their needs. Waiting times, delays and cancellations were managed appropriately.

Information relating to opening hours and appointments was available to patients on the practice website, practice leaflet and in the surgery. This included: booking appointments over the telephone or in person, how to arrange home visits and requesting urgent appointments during the day. The practice was open: between 8.30am and 7.30pm on Mondays; 8.30am to 6.30pm on Tuesdays, Wednesdays and Friday; and 8.30am to 12.30pm on Saturdays.

The practice had completed an audit to determine if demand existed for Saturday morning appointments opening before providing the service. The practice started opening on Saturday mornings from 11 October 2014, and a high demand for both GP and nurse appointments had been noted. Patients of working age had given positive verbal feedback in relation to the extended hours and felt it was very beneficial to them to be able to attend the surgery at the weekend.

Some appointments were available outside of school hours for children and young people. Flexible appointments were available to patients with mental health needs during less busy times to ensure a less stressful experience for the patient and their carer. The practice also sent out text message reminders for appointments and test results; with the opportunity to complete the family and friends test after the appointment.

Suitable arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. This included information on the out-of-hours service provided by Nottingham Emergency Medical Services (NEMS), 999 ambulance services, and when less urgent the NHS 111 medical helpline. Comments received from patients showed patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This included: the practice manager being

Are services responsive to people's needs?

(for example, to feedback?)

the responsible person for dealing with all complaints and information being made available to help patients understand the complaints system. For example posters were displayed in the waiting area on how to make a complaint and information was also available in the practice leaflet and website. Six out of seven patients we spoke with told us they had not needed to make a complaint and felt confident to discuss any concerns with the GP and / or practice staff.

We looked at four complaints received in the last 12 months and found these were logged centrally, investigated and responded to in a timely way; in accordance with the practice's complaints procedure. We noted that one complaint had been shared with NHS England and they had advised that the complaint had been dealt with appropriately within the practice. Records showed the practice had discussed their investigation findings with the complainants and where appropriate, apologised to the patient and explained the action taken to address the concerns.

We found lessons learned from individual complaints had been acted on and were reviewed annually to ensure shared learning and detect themes or trends. Staff told us complaints were discussed during team meetings and improvement actions agreed. For example, as a result of two separate complaints changes were made to policies and procedures relating to travel vaccination requests and fees charged for producing letters of support for patients.

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 and values to ensure patients received high quality care. This included: being receptive to patient needs and expectations in line with up to date developments in primary health care; respecting patient diversity and equality; as well as demonstrating integrity in the provision of services.

The GP provided us with examples and written evidence to demonstrate the progress made and future plans to achieve the vision and values. For example, on-going use of clinical data and multi-disciplinary working to identify opportunities to drive improvements in patient care and outcomes.

Staff we spoke with demonstrated awareness of how their individual roles promoted good outcomes for patients; and most of them knew and understood the practice vision and values. The practice should ensure that the vision and values are clearly recorded and accessible to both staff and patients.

Governance arrangements

There was a clear leadership structure in place with defined systems of accountability. This included the GP, practice manager, three nurses, one health care assistant and three administration staff. We spoke with five 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 was taken over by the current GP in November 2013; and records we looked at showed significant improvements had been made to overcome challenges related to information and workforce governance arrangements. This included reviewing and updating policies and procedures that governed both clinical and non-clinical activities within the practice, and establishing a new practice team.

We found the practice had a number of policies and procedures in place relating to the day to day running of the practice. This included policies relating to: data management, safeguarding vulnerable adults' medicine management activities and health promotion protocols. These policies were available to staff in a folder or the practice computers' shared drive and most staff we spoke with knew where to find these policies. In response to feedback given during our inspection, we received written evidence to confirm that staff had read and understood the practice policies relevant to their roles.

The practice manager was responsible for human resource policies and procedures. Records reviewed showed the practice had engaged the support of an external organisation to support them with updating their human resource policies and processes to ensure they were appropriate. As a result of this joint working arrangement, improvements were being made to the recruitment and staff training processes. The practice manager acknowledged this was an area of ongoing development and learning; and these were our findings during the inspection.

The GP took the clinical lead in assessing and monitoring the service provision with the support of the practice staff. This included undertaking clinical audits to monitor the management of specific patient health care needs, identify risks and take appropriate action to address them. For example, the GP had undertaken a chronic kidney disease (CKD) audit where patients' estimated glomerular filtration rate (GFR is a measure of the function of the kidneys) was reviewed.

The resulting information prompted some patients being advised to have a more up-to-date blood test to determine the correct of stage of the CKD in line with the National Institute for Health and Care Excellence (NICE) guidelines. This ensured that patients received right care in line with best practice. The NICE provides national guidance and advice to improve health and social care.

The practice used the Quality and Outcomes Framework (QOF) and data from the Clinical Commissioning Group (CCG) to measure its performance and inform decision making related to clinical care. The 2013/14 QOF data showed that the practice was performing in line with national standards; with some QOF outcomes higher than the CCG average. This included areas such as prevention of coronary heart disease, diabetes and heart failure.

We saw that QOF data and performance against a variety of CCG led targets were discussed at monthly team meetings. However some of the meeting minutes were brief: about discussions held, the agreed responsibilities and action plans to maintain or improve patient outcomes. This was shared with the provider as an area of improvement.

Are services well-led?

Good

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

The GP also told us they took part in a local buddying and peer review system with neighbouring GP practices. This gave the practice the opportunity to measure its service against others, identify areas for improvement and share learning.

The practice had arrangements for identifying, recording and managing risks. However this was not formalised into a central risk log. The practice manager showed us logs that were kept in relation to incidents, complaints and performance targets and there was evidence of them being completed in a timely way. Risk assessments had been carried for some identified risks such as fire, and action plans had been produced and implemented to mitigate risks.

Leadership, openness and transparency

We found the GP had a strong sense of responsibility for the practice's performance with a task orientated approach to improving patient health outcomes and address any poor practice. Staff we spoke with told us an open and friendly culture was promoted within the practice and they felt comfortable raising any concerns. Staff described the benefits of being a small practice team in terms of effective communication, collaborative working and supportive relationships.

The GP and practice manager told us they had an "open door" policy and encouraged both informal and formal discussions within the team. This was confirmed by staff we spoke with and monthly meeting minutes reviewed. The practice had whistleblowing and "blame free culture" policies to support staff in raising any concerns they had for example.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received. For example, in response to patient feedback about being overheard in reception, a prominent sign stating "worried about being overheard? Ask to speak to a member of reception in private" was displayed at the reception. The practice noted that although the number of patients requesting a private room was still quite small, receptionists felt there had been an increase in patients requesting this.

The practice had an active patient participation group (PPG) which included representatives from the working age and older people population groups; of white British, black African and Asian origin. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The practice had an on-going advertising campaign to recruit new members especially the young people population group which was underrepresented.

We reviewed the annual patient survey for October-November 2013, which was developed together with the PPG. The survey questions focused on the cleanliness of the practice and patient satisfaction with the repeat prescription process. 30 out of 50 questionnaires distributed were completed.

The results showed 93% of respondents had no concerns about the cleanliness of the practice and 7% reported they had concerns but offered no further comments on what these concerns were. 96% of patients on repeat medicines reported there were happy with the service and the electronic prescribing service had recently been introduced in the practice. The practice had also responded to comments received about litter picking outside the surgery and fly tipping issues by liaising with the local council to look at possible improvements. The results and agreed actions from this survey are available on the practice website.

The practice gathered staff feedback through staff meetings, appraisals and informal discussions. Most staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and themselves.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their professional development through training and mentoring. This was reflected in three staff files that we looked at and confirmed by staff we spoke with. For example, staff had received their annual appraisal which included a personal development plan and had various certificates on file to confirm training attended.

The practice manager told us they had received mentoring support from the Local Medical Committee (LMC) and other practice managers within the locality as part of their

Are services well-led?

Good

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

learning and development. The LMC represent GPs and practice teams in their negotiations with decision makers and stakeholders from health and local government to get the best services for patients.

The Medical Centre is a teaching practice for first, second and fifth year medical students. Student comments were positive about the level of supervision received including opportunities for learning and feedback on their performance. The GP is keen and working towards becoming a teaching practice for GP registrars.

The practice completed reviews of significant events and this was shared with staff to ensure the practice improved outcomes for patients. Records reviewed showed the discussion held to address the significant event and the resulting learning. This included follow-up action to address delays in urgent secondary care referrals and drug errors made by practice staff to ensure patient safety. In addition, practice policies and processes were updated; with staff receiving additional training where required and spot checks of administration processes undertaken.