

High Green Medical Practice

Quality Report

Mary Potter Centre in Hyson Green
Gregory Boulevard
Nottingham
NG7 5HY

Tel: 0115 942 2701

Website: www.highgreenmedicalpractice.co.uk

Date of inspection visit: 12 February 2018

Date of publication: 30/05/2018

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?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

Overall summary	2
The six population groups and what we found	4

Detailed findings from this inspection

Our inspection team	5
Background to High Green Medical Practice	5
Detailed findings	6

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at High Green Medical Practice on 12 February 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. They took a proactive approach in relation to safeguarding children and vulnerable adults.
- There were reliable systems for managing medicines and equipment, with systems in place to ensure that any alerts and guidance were reviewed and acted upon.
- Patients with long-term conditions had not always received an annual review of their healthcare needs, but the practice was aware of this and was working to encourage patients to attend.
- The practice encouraged the take up of child immunisations and cervical smear tests by promoting the importance of these to mothers and coordinating appointments to facilitate easier attendance.
- The practice's uptake for cervical screening was in line with CCG and national averages.

Summary of findings

- Patients with a learning disability were offered reviews of their healthcare needs and the practice worked with local specialist services to encourage uptake of these reviews.
 - The practice had a programme of quality improvement activity in place and there was evidence of audits being used to help drive improvement.
 - The most recent published Quality Outcome Framework (QOF) results showed that the overall exception reporting rate was 20%, compared with a national average of 10%. The practice was aware of their higher than average exception reporting and lower than average QOF results. We were told this was due to specific patient characteristics. They were taking a proactive approach to improve on this and encourage more patients to attend for their health reviews. There were systems in place to monitor their progress in this area.
 - Interpretation services were available for patients who did not have English as a first language. Some staff were multi-lingual and able to speak to patients in other languages.
 - Comments received during our inspection showed patients felt that they were treated in a caring and compassionate manner and their dignity was respected. These comments were more positive than the results from the July 2017 annual national GP patient survey which had showed patients' satisfaction with how they could access care and treatment was significantly below local and national averages for some indicators. The practice had taken action to address this and feedback during our inspection indicated some patients were experiencing improvements.
 - The practice demonstrated an understanding of the needs of their patient population and described steps they took to help ensure their patients accessed appropriate care and support.
 - Openness, honesty and transparency were demonstrated in the way incidents and complaints were dealt with. Staff felt that they could raise concerns and would have no hesitation in doing so.
 - The practice sought the views of patients in a variety of ways, including using a virtual patient participation group, face to face discussions with a smaller group of patients who acted as a consultative group and carrying out their own internal survey.
- The areas where the provider **should** make improvements are:
- Continue to manage and monitor processes to improve outcomes for patients.
 - Improve opportunities for the uptake of national screening programmes for bowel cancer and breast cancer.
 - Continue to address the issues highlighted in the national GP survey in order to improve patient satisfaction, including access to appointments.
 - Consider developing the patient participation group to formalise how patients are involved in monitoring the quality of the service and helping to drive improvements.

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

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

High Green Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience.

Background to High Green Medical Practice

High Green Medical Practice is located within the Mary Potter Centre in Hyson Green, Gregory Boulevard, Nottingham, NG7 5HY and is registered with the Care Quality Commission to deliver regulated activities from this location. We visited this location to carry out our inspection.

The registration details of this location changed in July 2017 and this was our first inspection of this service since its new registration.

There are 10,034 patients registered with the practice and 65% are from black and minority ethnic groups. There was a high turnover of patients and over 2,730 new patients had registered with the practice during 2017 and 1987 had been deducted. This was a movement of 4717 patients in 2017.

The number of patients at this practice who have a long standing health condition is 48%, which is in line with the CCG average of 54% and the national average of 54%.

The practice is in one of the most deprived areas of the country, based on the Index of Multiple Deprivation, which is the official measure of relative deprivation in small areas of England.

The practice is registered as a partnership and has two GP partners, one male and one female. There is also a salaried GP who works at the practice two days per week. The practice provided an average of 47 GP sessions per week.

The practice is an approved teaching and training practice for medical students and GP registrars. (A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice.)

Further information about the practice can be found on their website; www.highgreenmedicalpractice.co.uk

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- One of the GPs had a lead role for safeguarding in the practice. Following a recent meeting with the local clinical commissioning group (CCG) safeguarding team the lead GP had reviewed practice processes against the CCG standards. This had resulted in identification of some areas for action and improvement, including introducing some new processes.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out (DBS)
- Staff received safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones had been trained for the role and received a DBS check.
- There was an effective system to manage infection prevention and control. One of the nurses took lead responsibility for this area, which included carrying out audits and implementing any necessary actions.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Locum GPs were used on some occasions and these were usually regular locums, familiar with the practice systems and processes.
- There was an effective induction system for temporary staff tailored to their role. This was confirmed by the temporary staff we spoke with who explained they received relevant information and appropriate support to assist them in carrying out their roles.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention, having received training to support them in this. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. A sepsis toolkit linked to the electronic record system was used to aid timely identification and treatment.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information and there were processes in place to ensure referrals were made in a timely way. Information, such as test results and hospital discharge letters, were reviewed promptly by the practice when received.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, and emergency medicines and equipment

Are services safe?

minimised risks. There were regular checks to ensure there were appropriate supplies in doctor's emergency bags. The practice kept prescription stationery securely and monitored its use.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed their antimicrobial prescribing data and their most recent analysis showed prescribing levels were at an appropriate level. They had provided patients with written information about antibiotic prescribing to raise awareness of this issue.
- The practice reviewed guidance provided by The National Institute for Health and Care Excellence (NICE), shared this at monthly clinical meetings and kept a record of the topics they had covered. For example, in January 2018 guidance on antimicrobial prescribing for acute sore throats had been disseminated and discussed.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents and the learning from these was shared amongst the team. Staff understood their duty to raise concerns and report incidents and near misses. They felt confident that any concerns they had would be listened to. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an error where a prescription had been collected by the wrong patient, additional checks were introduced to avoid a similar occurrence in the future.
- There was a system for receiving and acting on safety alerts. The practice had outlined these arrangements in a written protocol, which included maintaining a log of all such alerts. Records confirmed alerts had been reviewed, disseminated to relevant staff and action taken where needed. These alerts were also discussed in relevant practice meetings.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and all of the population groups as requires improvement for providing effective services.

The practice was rated as requires improvement for providing effective services because:

- Patients with long-term conditions did not always attend for a structured annual review to check their health and medicines needs were being met.
- Uptake for national screening programmes for bowel cancer and breast cancer were below local and national averages.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. New and updated guidance was reviewed on receipt and considered at regularly held clinical meetings. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Audit activity was aimed at improving patient care and included re-audits to check progress. Recent audits had included diabetes care, monitoring arrangements for patients on high risk medicines and the numbers of appointments where patients failed to attend and there was evidence to demonstrate the audits were used to help drive improvement. For example, the practice had recently completed an audit of end of life care for patients which had identified some areas for improvement, this included greater consistency in the format of recording of patients wishes and needs via an electronic recording system. There

was evidence the practice were taking action in response to the findings of the audit and a second audit was planned to take place in 12 months' time to assess whether the improvements identified had been achieved.

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 85% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 96%. This had seen an increase of 8% compared to 2015-16 results. The overall exception reporting rate was 20% compared with a national average of 10%. This had seen an increase of 12% since the 2015-16 results. In the examples we reviewed, we found the reasons given for exception reporting were appropriate. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice had a detailed understanding of the factors which impacted on patients attending for monitoring and review of their health conditions. Over 65% of patients were from black and minority ethnic groups and many had limited spoken English. This presented some barriers in helping patients to understand the processes and importance of regular reviews. There was a high turnover of patients and many new patients arrived from abroad with no medical records, no previous experience of the NHS and needed a greater level of support to help them understand the processes.
- In response to these challenges, the practice were proactive in trying to encourage more patients to attend for their reviews and had systems in place to monitor progress. The practice sent invitation letters and followed these up with telephone calls, where appropriate using interpreters so they could communicate the reasons for the appointment in the patient's first language.

Older people:

- The practice participated in annual immunisation campaigns for flu, shingles and pneumonia.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

Are services effective?

(for example, treatment is effective)

- The practice followed up on older patients discharged from hospital and ensured care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Patients with long-term conditions had not always attended for a structured annual review to check their health and medicines needs were being met. The practice were aware of this and were taking action to try and encourage patients to attend. The practice told us that a number of their patients travelled abroad for long periods of time, often a couple of months at a time, which meant it could be difficult to support them in managing any long term health conditions and to ensure they attended for monitoring and review. For example, the percentage of patients with asthma who had received an asthma review in the preceding 12 months was 51%, compared to the CCG average of 75% and national average of 76%. The practice had completed an audit of asthma care to help them identify ways to improve. Another area of low performance was the percentage of patients with rheumatoid arthritis who had received an annual review in the preceding 12 months, which was 59%, significantly below the CCG average of 91% and national average of 92%.
- To improve the completion of annual reviews the practice reserved one GP session a week for reviews of patients with long term conditions. This arrangement was introduced in 2017 in response to the practice auditing the numbers of patients attending for reviews. This dedicated time and a greater willingness amongst some patients to attend the surgery when they knew their appointment was with a GP was enabling reviews to be completed.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice took positive action to encourage the take up of child immunisations and cervical smear tests. Children aged under 6 registering with the practice were seen with their parent by a nurse, and an interpreter

present if appropriate. During this appointment the Personal Child Health Record (also known as the PCHR or red book) was checked, if available, and if there was no evidence of immunisations these were scheduled immediately. Where needed, if consent was gained, the immunisations were carried out at the initial appointment. (The PCHR is a national standard health and development record given to parents/carers at a child's birth.)

- New babies were invited to the practice for an eight week baby check with a GP and to begin their immunisations with a nurse. The nurse used the opportunity to explain the immunisation programme and to discuss contraception and cervical smears. If a cervical smear was due an appointment was made to coincide with the baby's next immunisations at 12 weeks.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 78%, compared to the CCG average of 75%, and national average of 76%. This was in line with the 80% coverage target for the national screening programme.
- Uptake for national screening programmes for bowel cancer and breast cancer were below local and national averages. 49% of patients had been screened for breast cancer compared to the local CCG average of 71% and national average of 73%. 33% of patients aged below 74 years had been screened for bowel cancer, compared to the CCG average of 56% and national average of 59%. The Practice was aware of these low uptake rates and took steps to encourage patients to attend. When invitation letters were sent they included written information in the patients chosen language. If patients failed to attend for screening the practice continued to try and encourage them to do so. They contacted them by telephone to discuss any concerns and provided further information, including inviting patients to visit the surgery to discuss the matter with a clinician. Text messages were also used to send patients links to YouTube videos in languages other than English, explaining the reasons for bowel cancer screening and to describe

Are services effective?

(for example, treatment is effective)

the procedure. The practice audited their follow up telephone calls to patients to help them understand the reasons for patients' refusal and consider new ways to improve in this area.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Within the last 12 months the practice had completed an annual health review for 10 of the 28 eligible patients on their learning disability register. A further 7 patients had appointments booked for their reviews to take place over the next month. The practice continued to try and encourage the remaining patients to attend by making further contact with them, including telephone calls by the practice nurse. Longer appointment slots of 30 minutes were allocated for these reviews and if a patient was unable to attend the practice, arrangements were made for the review to take place at their home address. When the patient had a carer, the carer was consulted as part of the review. At the end of each quarter the practice reviewed their progress and submitted monitoring data to the Learning Disability Primary Care Liaison Team. This included advising the team of patients who had received three invitations but had still failed to attend the practice so the team could encourage and support these patients to attend.

People experiencing poor mental health (including people with dementia):

- 73% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was below the national average of 84%.

- 84% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan document in the previous 12 months. This was just below the national average of 90%.
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 77%. However, this was below CCG (89%) and national (91%) averages.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when

Are services effective?

(for example, treatment is effective)

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. They held monthly meetings to review the needs of each patient receiving end of life care.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. This included signposting patients to self-help groups.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. They referred patients to services that would help them live healthier lives, including smoking cessation advice, exercise on prescription and weight loss groups.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff were mindful of patient privacy and knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients commented that they found staff to be caring. We received 30 completed Care Quality Commission comment cards during the inspection and 28 of these cards were wholly positive about the way the patients felt they were treated. The remaining two cards gave a mix of positive and negative comments. The 17 patients we spoke with during our inspection confirmed that they were satisfied with the services they received. These patients told us that they felt that they were treated respectfully and with care and compassion.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 388 surveys were sent out and 78 were returned. This represented less than 1% of the practice population. The practice was mostly in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 78% of patients who responded said the GP gave them enough time; CCG - 84%; national average - 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.

- 79% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 84%; national average - 86%.
- 91% of patients who responded said the nurse was good at listening to them; (CCG) - 90%; national average - 91%.
- 90% of patients who responded said the nurse gave them enough time; CCG - 90%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 89%; national average - 91%.
- 81% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 87%.

We also spoke with 17 patients during the inspection and received 30 completed comment cards. This feedback mirrored the findings from the national GP patient survey and showed the majority of patients felt they were treated with compassion, dignity and respect.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. There were also some multi-lingual staff who were able to speak to patients in other languages. For example, we noted staff on reception spoke with patients in English, Urdu, Punjabi and Polish. Patient records included details of their preferred language.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

The practice identified patients who were carers. This was done at the point of registration or at a later point if a

Are services caring?

member of staff became aware of a change in a patient's circumstances which resulted in them becoming a carer. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 117 patients as carers (1% of the practice list).

- A member of staff acted as a carers' champion to help ensure information held about carers was up to date and that suitable information could be shared with identified carers. For example, carers had recently been sent a letter containing information about local services which could provide carer support.
- Following bereavement the practice sent messages of condolence and offered any advice or support that might be needed.

Results from the national GP patient survey showed mixed results from patients when asked questions about their involvement in planning and making decisions about their care and treatment. Results were either in line with or below local and national averages:

- 80% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.

- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 89%; national average - 90%.
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 83%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. For example, we observed staff on the reception desk were discrete in their conversations with patients arriving at the practice.
- The practice complied with the Data Protection Act 1998. There were policies in place to support the way patient information was handled, all staff signed confidentiality agreements and received training in the handling of information.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. 800 patients (35%) were new to the UK and had not previously been registered with an NHS practice, so were unfamiliar with the processes and many required support from interpreters. The practice used this information to help them develop the way services were delivered. For example, the practice monitored the number of appointments that required an interpreter, including interpreters arranged by the practice and those where family and friends acted as interpreters. Over the previous five months an average of 152 interpreter assisted appointments had been booked each month and the practice knew appointments using an interpreter usually took longer. They had responded by allocating some longer appointment slots to each GP session to support this.
- Patients were encouraged to use online services and 17% of them had registered to book appointments and request repeat prescriptions in this way. To encourage patients to make use of this service the practice website was available in eight different languages.
- The practice had extended the range and availability of clinical skills at the practice. There were two practice nurses who were both training to become prescribers. A paramedic was employed as a primary care practitioner (Paramedic) and saw patients with minor illnesses for same day appointments.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. The practice reviewed the needs of these patients in clinical meetings to ensure support was tailored to their individual circumstances.

Older people:

- Patients aged 75 and over had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice supported a number of care homes and those we spoke with as part of this inspection told us they were satisfied with the support they received from the practice, which included regular visits by one GP, which helped ensure continuity of care for patients.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition were all offered an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. The practice experienced challenges in this area and made significant efforts to encourage patients to attend for these reviews. To address this the practice had reserved one GP session a week for reviews of patients with long term conditions. This dedicated time and a greater willingness amongst some patients to attend the surgery when they knew their appointment was with a GP was enabling reviews to be completed.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients had care plans in place to explain how their individual needs were being supported.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

Are services responsive to people's needs?

(for example, to feedback?)

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group 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, early morning and evening appointments were available with GPs and nurses.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Home visits were made in circumstances where visiting the practice might cause a patient distress.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Annual health checks were offered for patients with long-term mental health problems and for patients with dementia. Patients who failed to attend were proactively followed up by the practice.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Changes had very recently been made to the telephone system to help make it easier for patients to contact the practice.
- Waiting times, delays and cancellations were minimal and managed appropriately. The practice monitored these areas to help them improve arrangements.

- Patients with the most urgent needs had their care and treatment prioritised and same day appointments were available.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly below local and national averages for some indicators. 388 surveys were sent out and 78 were returned. This represented less than 1% of the practice population.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 37% of patients who responded said they could get through easily to the practice by phone; CCG - 71%; national average - 71%.
- 61% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 82%; national average - 84%.
- 58% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 53% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.
- 54% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 64%.

In response to the national GP patient survey results and other feedback from patients the practice had taken action to improve access to appointments. They had recently introduced a new telephone system which included a call queuing facility and an announcement to confirm to the caller where they were in the call queue. A number of patients we spoke with during our inspection told us that they had experienced recent improvements in contacting the practice by telephone, which they attributed to this new system. The practice monitored incoming telephone calls, which gave them an understanding of the volume of calls and the busiest times of day. This information had been taken into account in the implementation of the new telephone system. Longer appointment slots had been added to each GP session to accommodate the use of interpreters during consultations. The practice had also

Are services responsive to people's needs?

(for example, to feedback?)

increased the range of appointments available by using nurses and their newly appointed primary care practitioner (Paramedic) who saw patients with minor illnesses for same day appointments.

On the day of inspection we explored levels of patient satisfaction about access to appointments by reviewing completed Care Quality Commission comment cards and speaking with 17 patients to ask for their views. The majority of completed comment cards showed patients were pleased with the service they received, with five negative comments (17% of the total responses) related to accessing appointments. Our discussions with patients also showed most were satisfied and felt that they could access care and treatment when they needed to.

The practice were carrying out their own internal patient survey which was due to close on 31 March 2018. The survey mirrored many of the questions in the national GP patient survey. In response to this inspection the practice collated the responses already received. Although the number of patients who had responded so far was small, with just 12 responses received, these interim results showed improved satisfaction levels;

- 75% of the patients who responded said they were satisfied with the practice's opening hours.
- 67% of patients who responded said that they could get through to the practice easily by phone.
- 92% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment.

This feedback indicated that the changes the practice had been making were bringing about improvements for patients.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. There were leaflets available in the reception area in a variety of languages and information was also included on the practice website. Staff treated patients who made complaints compassionately. Staff we spoke with explained that they would do what they could to resolve any concerns patients had.
- The complaint policy and procedures were in line with recognised guidance. 30 complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the practice had identified that the majority of complaints (26%) related to difficulties in booking appointments and had taken action in response to this. They had improved the practice telephone system, reviewed the way appointments were used, extended the range of clinical skills available at the practice and promoted the use of online booking.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. The practice had identified that they faced particular pressures due to the economic and cultural make up of their patient population.
- In 2017 they had contributed to an independent review of primary care services in the Hyson Green area of Nottingham which had been completed by Healthwatch Nottingham. Findings had been shared with participating practices and the clinical commissioning group in October 2017. The report had confirmed the concerns raised by the practice and highlighted that although the population of the area had always been poor and multi-cultural things had evolved; the area was relatively poorer, even more multi-cultural and much more transient. The report found the combination of factors led to a new set of challenges for primary care.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There were supporting plans in place to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

- Staff stated they felt respected, supported and valued. They felt the whole staff team worked together well, and that individual staff members would do whatever they could in order to provide the best service possible for patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and would have no hesitation in doing so. They found senior staff to be approachable had confidence that their concerns would be addressed.
- There were processes for providing all staff with the development they need. This included annual appraisals and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. Trainees and locums also felt well supported by the practice. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- The practice were mindful of the safety and well-being of all staff. For example, relevant training had been provided to help reception staff manage challenging situations.
- Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.

Are services well-led?

Good 

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. For example, the practice used monitoring information about the number of incoming calls received at different times of the day and used this to help make improvements for patients.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.

- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- Patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The practice was carrying out an internal patient survey which was due to close on 31 March 2018. The survey mirrored many of the questions in the national GP patient survey. In response to this inspection the practice collated the responses already received. Although the number of patients who had responded so far was small, with just 12 responses received, these interim results showed improved satisfaction levels;
- There was a virtual patient participation group of 300 patients. The practice circulated information electronically to this group and invited patients to put forward their views.
- The practice had promoted the NHS Friends and Family test amongst their patients, using text messaging to prompt patients to complete the survey. Results were used to help make improvements and showed that the proportion of patients saying they were likely to recommend this service had been increasing over the last 12 months. The NHS Friends and Family Test (FFT) is an anonymous way for patients to give their views after receiving care or treatment across the NHS. It was created to help understand whether patients are happy with the service provided, or where improvements are needed.
- There was also a smaller a group of patients who acted as a consultative group for the practice. We met members of this group during our inspection and they described how they met together occasionally, the practice asked for their feedback and was interested in

Are services well-led?

Good 

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

their experiences of using the service. They felt listened to and appreciated by the practice. However, there was no formal structure for these meetings or any records to demonstrate the achievements of the group.

- The practice engaged in health promotion campaigns by making information available to their patients and also using social media to promote key messages. This had included participating in local radio discussions about healthy lifestyles and having an information stand at local community events.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The

practice was developing their staff skill mix to be able to offer improved support for patients. This included supporting nurses to train as prescribers and employing a Primary Care Practitioner (Paramedic) to treat minor illnesses.

- Staff knew about improvement methods and had the skills to use them. For example, audits were used to review performance and identify areas for improvement.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared, including at staff meetings, and used to make improvements.
- The surgery was a GP training practice and accommodated placements for GP registrars and medical students. This facilitated an environment of continuous learning and contributed to the practice's quality agenda.